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ABSTRACT

Children's school experience is more positive and productive when they have a sense of personal well being and when they are grounded in stable caring relationships in their early lives. Developed for Head Start staff, administrators and program supervisors, this issue includes features, resources and articles. Some of the most current interventions and concerns impacting child mental health including the quality of relationships in centers, the ways curriculum supports emotional connections, and the honest acknowledgement of strengths and challenges are described. Sections in the issue include: A Welcome to Windy Hill; Daily Separations and Reunions; Stress and the Developing Brain; and the Effects of Violence on Mental Health. Issue Pull-Out in English and Spanish entitled, Helping Children and Adults Cope with Trauma in the Community = Como Ayudar a los Ninos y a los Adultos a Enfrentar Sucesos Traumatizantes en la Comunidad, is also included. (GCP)

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Child Mental Health

Jeff Fredericks, Editor

Head Start Bulletin n73 2002

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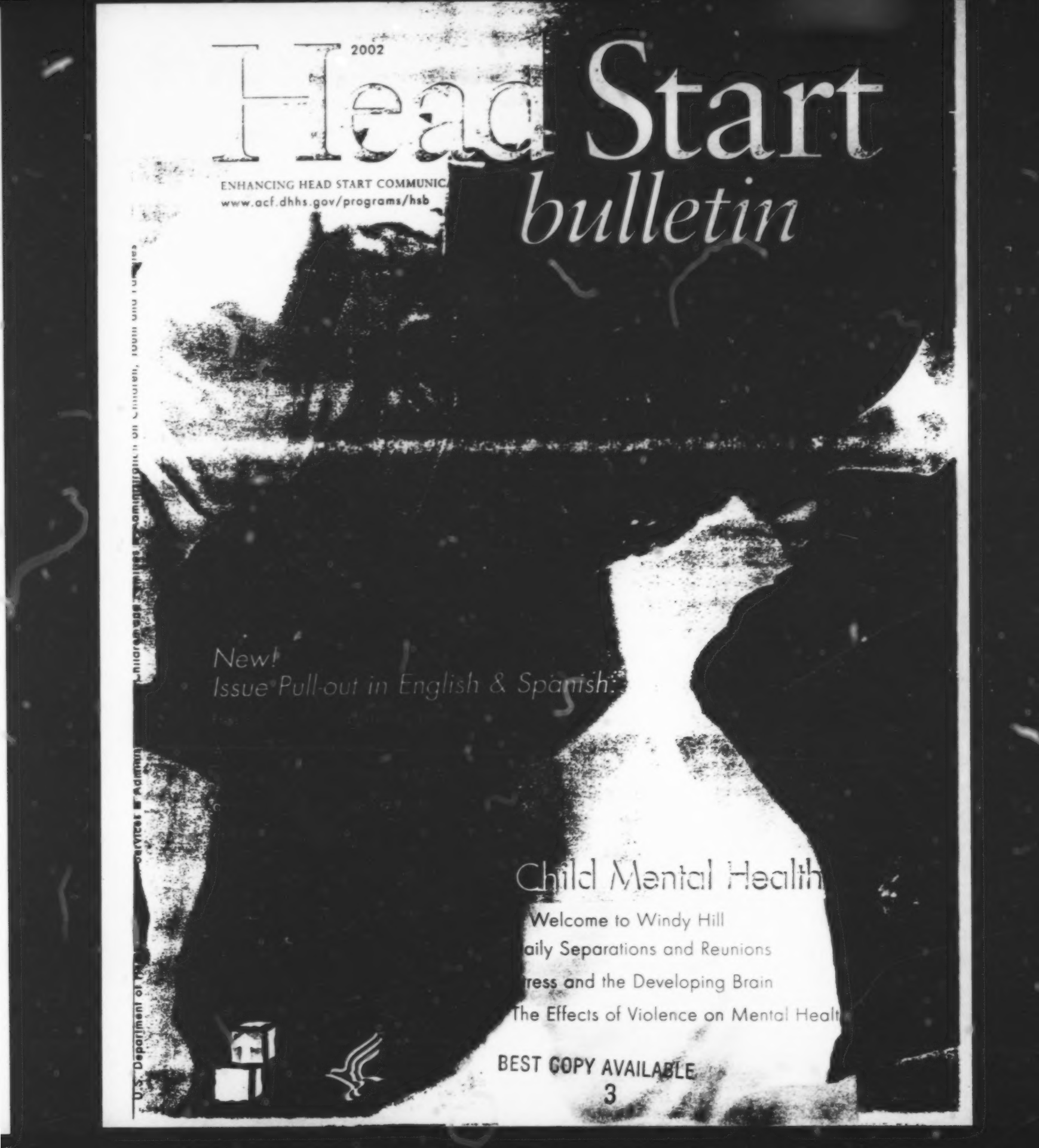
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Child Mental Health

THE NOTION OF PROMOTING social-emotional development and mental health is not new to Head Start. In his 1979 critique of the Head Start Program, Edward Zigler, one of its founders stated, "We should have never allowed the intelligence (IQ) score to become the ultimate indicator of compensatory education's success or future...The goal of Head Start is the production of socially competent human beings."

The development of social competence and school readiness is of paramount concern to our society. Social and economic changes in the country are posing challenges to parents as they attempt to balance spending quality time with their children with making a living and protecting them from environmental risks affecting their health and development.

As a national laboratory, Head Start has always been a leader in the field of early childhood, recognizing the needs of low-income young children and acknowledging the impediments that need to be addressed to help them learn and grow. Children's school experience is more positive and productive when they have a sense of personal well-being and when they

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are grounded in stable, caring relationships in their early lives. Unhappy, fearful, or angry children are preoccupied with their struggles and their pain. This makes them unable to give their full attention and engagement to learning experiences.

Mental health needs exist on a continuum. Services to address those needs can range from activities and interventions designed to help children develop self-confidence; to interventions for children dealing with socio-economic disadvantages and social disorganization, abuse, and family disruptions; to diagnosed disabilities and health challenges. The relatively new field of infant mental health brings a multi-disciplinary perspective that enhances our understanding of infant competency, the parent/infant relationship, child development, and risk and protective factors that affect development, assessment, prevention, and intervention. This perspective seeks to enhance a family's strengths while addressing those circumstances that can threaten it.

The impacts of poverty, substance abuse, violence, physical and sexual abuse, and teen pregnancy are undeniable. Early Head Start and Head Start can help facilitate the unfolding of healthy self-esteem and internal regulation. They can teach how to tolerate, experience, and modulate deeply felt emotions—skills that lead to social competence and the capacity to participate in a learning environment.

Some key social skills are respecting the rights of others, relating to peers without being too submissive or too overbearing, being willing to give and receive support, and treating others the way one would like to be treated. Recent early childhood research, such as *From Neurons to Neighborhoods* and the *Surgeon General's Report on Children's Mental Health*, has demonstrated that developing social skills are seriously affected by the infant or young child's early experiences and the quality of early relationships. What Early Head Start and Head Start staff members do in a variety of settings and with a variety of populations can have a monumental effect on families and on society. We know that the chances of favorable outcomes, particularly when working with extremely vulnerable, emotionally damaged populations, are increased when we create nurturing, responsive environments and well-informed, well-planned interventions based on current knowledge and outcomes-based research.

As Head Start continues to encourage increased knowledge and advanced credentials within its programs, staff must also bring an increased sensitivity, awareness, sophistication, and skill level in addressing creatively the mental health needs of our children and families. The emotional needs of children and families dealing with serious life issues require a new level of emotional commitment and strength from the staff who works with them. Staff members who work with families dealing with challenging situations need to identify and reinforce their strengths, celebrate their successes, and build on the positive relationships and experiences that Head Start provides. This, in turn, demands that administrators and program supervisors provide adequate training, supervision, and emotional support for staff facing the challenge of remaining emotionally present in the face of tremendous stress, emotional pain, and challenging behaviors.

The articles in this issue of the *Head Start Bulletin* describe some of the most current interventions and issues affecting pregnant women, father involvement, and children birth to five, as well as some innovative program models. The Head Start Bureau and its collaborative partners are committed to reinforcing the message that mental health does not just refer to interactions between patients and therapists but to the quality of relationships in our centers and the confidence we feel in successfully creating happiness in our lives. The ways that we use curriculum to support emotional connections, the honest acknowledgement of strengths and challenges, and how we support and encourage staff all reflect Head Start's mandate to create atmospheres of social competence and mental health. We invite you to consider how your program might be able to incorporate some of the successes described here to improve the lives of your children and families. In this *Bulletin*, we also introduce you to Windy Hill, the Associate Commissioner for the Head Start Bureau. Windy has been involved with Head Start for many years, as a child in the program and as a parent, and she is a strong advocate for all that is best for Head Start children, families, and staff.

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A WELCOME TO
ASSOCIATE COMMISSIONER WINDY HILL

WINDY M. HILL WAS NAMED THE ASSOCIATE COMMISSIONER for the Head Start Bureau on January 7, 2002. She brings a lifetime of involvement and commitment to the principles of the Head Start Program. As a child, she was enrolled in Head Start in Bastrop, Texas. Her child was also enrolled in the program. She has served as a parent representative on the center's policy council and later was part of the community group that developed and received a Head Start grant. Prior to joining the Head Start Bureau, since 1993, Associate Commissioner Hill served as Executive Director of Cen-Tex Family Services, Inc. which administers nine Head Start centers in a four-county region of central Texas.

Photography by ACF

At the Region 12 Migrant and Seasonal Head Start Annual Conference held in March 2002, Associate Commissioner Hill affirmed the initiatives affecting Head Start that include fatherhood, positive youth development, literacy, faith-based, and the rural initiatives. She explained, "We see these initiatives as tools to deliver better outcomes for Head Start children and their families."

Associate Commissioner Hill described the President's early childhood initiative at the NHSA conference in Phoenix in April 2002, "The President's *Good Start, Grow Smart* initiative will help states and local communities strengthen early learning for young children to make sure that they have the skills they need to start school ready to learn—to ensure that No Child Is Left Behind. To strengthen Head Start's school readiness efforts, the Administration will support the development of appropriate standards of learning in early literacy, language, and numeracy skills." She explained that "*Good Start, Grow Smart* is about making sure that programs have the support, guidance, and leadership that ensures quality Head Start environments; healthy, successful children; and empowered parents."

Associate Commissioner Hill is very committed to the Head Start vision. "I have experienced Head Start from different vantage points and seen how it has benefited my life and the life of my daughter. These experiences have taught me the value of Head Start and the importance of putting children first." Welcome Associate Commissioner Windy Hill.

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THE INFANT MENTAL HEALTH APPROACH

From their first moments, infants are busy building an emotional and social life by GRACE WHITE-TENKANY AND GERARD COSTA

When the Infant Mental Health (IMH) Specialist walks into the playroom, she sees Karina and her mother Karen. Six-month-old Karina sits in her infant seat on the table and Karen sits in a chair. They both face the door. Karen reads a magazine as Karina gazes at the side of her face. The IMH Specialist softly says, "Karina, is Karen the prettiest mommy you've ever seen?" Karen looks up and smiles at the IMH Specialist. The IMH Specialist then says, "Did you see how lovingly Karina was looking at you?" Karen laughs and tickles Karina's belly, saying, "You're such a silly baby!" Karina and her mother exchange sounds and giggles as the IMH Specialist looks on.

The home visitors happily chat over the complimentary breakfast that the agency provides for their meeting every Friday morning. They are also getting ready for their meeting with the Mental Health Consultant (MHC). Every Friday the MHC meets with the home visitors as a group and then holds a reflective supervision session with the home visitor supervisor. The supervisor, in turn, conducts individual supervision sessions with the home visitors. Everyone looks forward to Fridays because they feel appreciated, taken care of, and important.

THESE SCENARIOS ARE TYPICAL of any infant/toddler program that provides mental health services. Mental health services for pregnant women, infants and toddlers, and their families can take many forms, depending on the program and the families (e.g., consulting with staff, consulting with children and families, providing direct mental health services, etc.). Regardless of how mental health services are delivered, the understanding of mental health is the same: prevention first, promotion always, and intervention when necessary.

Before making recommendations and decisions to guide the mental health services in a program, the first step is to understand infant mental health. This article will illustrate the infant mental health approach by providing a historical and philosophical context, identifying infant mental health guiding principles, and outlining examples of infant mental health program features.

Infants and Mental Health

THE TERM "INFANT MENTAL HEALTH" conjures up odd images for many—even for those people who have worked for years in early childhood settings. Some have never considered the words "infant" and "mental health" together. Some think of the negative and stigmatizing meanings of "mental health" and are surprised that infants can have mental health problems. Unfortunately, some view mental health as a human quality or a field of work that is concerned with deficits in people.

Infant mental health affirms that mental health is a *positive* aspect of human development (although we address problems when they arise) and the field of mental health is both proactive and reactive—hence the prevention, promotion, and intervention approaches noted earlier.

From their first moments, infants are busy building an emotional and social life. Infants' emotional development forms basic notions about the self and the world. Development in all other areas—cognition, communication, and motor skills—is organized by the emotional development of the child. Most importantly, the infant's development begins and continues within the context of an emotional relationship. As Donald Winnicott (1987), famed pediatrician turned child analyst stated, there is no such thing as an infant

Photography by Eyewire

alone. We must always consider the infant/caregiver relationship. Emotional life is fundamentally a relational life. We must always view infants in the context of their earliest attachment relationships. This relational focus is relevant throughout early childhood—and throughout life.

Infant Mental Health as a Field

THE PROCESS WHEREBY INFANTS AND PARENTS attach or have difficulty attaching to each other, and the factors that influence this dynamic and vulnerable process constitute the field of infant mental health. It is an interdisciplinary field that studies the optimal emotional, social, physical, communicative, and motor development of infants within the context of their earliest primary relationships.

Selma Fraiberg (1987), Social Worker and Child Analyst at the University of Michigan at Ann Arbor, is credited as the founder of infant mental health as a distinct field of intervention. She founded the Child Development Project at Ann Arbor which created influential ways of understanding and treating problems in the infant/parent relationship—most notably the notion that all work must be dyadic, meaning that the dyad, or pair, to always consider is that of the infant and parent. This gave rise to unique methods of intervention, particularly infant/parent psychotherapy and home-based services (sometimes called "kitchen-based" therapy, *see article on page 39*). This emphasis on the relationship, rather than on the child or parent alone, forever changed the methods used in understanding and helping infants and their families.

While students and professionals who study and work with infants and their families come from many different fields, there are certain principles that guide this work for everyone.

Guiding Principles

1 The human infant comes into the world with remarkable capacities for human relatedness—with Attachment Promoting Behaviors (APBs)—that help invite, inform, and regulate relationships with the caregiver. From the earliest moments, infants require consistency, stability, predictability, availability, and attuned love.

2 The period of life from birth to three is a sensitive period of development for the formation of character or personality. The greatest period of brain development, the brain "growth spurt", occurs from the last trimester of pregnancy through the first 18 months of life. During this period, nutritional, physical, social, and emotional satisfactions and failures will be "biologized," meaning that actual changes occur in the physical and chemical structures in the brain.

3 Pregnancy and childbirth are powerful conscious and unconscious reminders in the parent of childhood issues that can help or hinder the parent in responding to, caring for, and loving the infant. In every birth, the infant can serve as a powerful transference object for the parent—meaning that thoughts, feelings, and beliefs about other figures and events in the parent's past can become associated and confused with the infant. Pregnancy, birth, and the first two years of maternal care require the availability of psychological resources, emotional support, and parent/infant psychotherapy. Parenting is a relationship, not a skill, and the belief that parenting can be "taught" as we do other skills is not clearly supported.

4 Those of us who work with infants and their parents also have our own emotional histories that influence how we work with families—especially those families where infants are not adequately cared for or are hurt. We are not immune from the same psychological forces that influence the parent/child relationship. Infant mental health requires that these feelings be addressed. Delivery systems and child protective agencies must provide protected time for intensive and rigorous staff training and ongoing regular supervision.

5 The nature of the infant/parent relationship is best understood within the setting of the family home because the context of family events (eating, sleeping, relating, nurturing) as well as the alternate ways parents communicate to us (through pictures, objects and toys, family stories and memories) are rooted in the family home.

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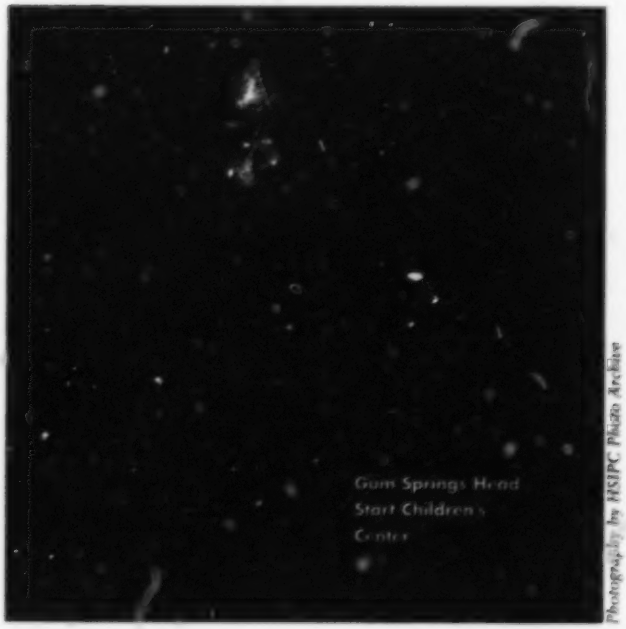
The infant/parent relationship emerges within a unique set of cultural and economic factors that provides a historical and practical context to the family and to the intervention. Infant care, expression of affection, use of health care, and relationships with mental health professionals are strongly influenced by these factors.

As we consider ways to integrate principles of infant mental health into Early Head Start and Head Start programs, we should consider the following points—

- Understanding infant mental health and working with a relationship-based approach are skills that are not exclusive to mental health professionals. These skills belong to all of us who work with infants and their families. Teachers, pediatricians, speech therapists, occupational therapists, bus drivers, nutritional staff, and all others within the Head Start family can learn ways to implement IMH practices.
- There are many strategies of intervention, including building an alliance with families and providing services and systems advocacy; developmental/parental guidance; supportive counseling; and more specialized services of infant/parent assessment and dyadic psychotherapy.



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Integrating IMH practices into Early Head Start and Head Start programs does not mean that everyone must now become a psychotherapist. Those who wish to develop these specialized mental health skills can participate in the growing number of graduate and post-graduate programs being developed throughout the United States. It does, however, mean that awareness of infant mental health and the importance of working in a relationship-based way with families must be supported through training, supervision, and consultation to ensure that the guiding principles are achievable.

To incorporate these principles, programs should consider several strategies to become more infant mental health centered.

Infant Mental Health Program Features

THE FOLLOWING FEATURES for an infant mental health program are typically implemented by using the program's internal capacity to provide mental health consultation or through collaboration with external consultants from local agencies. Any combination of employee or consultant services can be used. The design depends on the strengths and needs of the children, families, and staff, as well as on the program's human and fiscal resources.

When staff identifies children needing mental health assessment or services, a mental health professional can provide direct consultation to the children and families. This can be accomplished through playgroups that may include parents. These groups assist children in the initial learning of social skills, such as the capacity to wait, take turns, read the cues of adults and peers, and accept support from others. Groups with parents and their young children allow time for parents to enjoy their children and learn to play with them in sensitive and attuned ways. Staff is able to observe the interaction between the caregiver and child, assess the need for intervention, and model emotional presence and ways of handling emotionally challenging behaviors. This consul-

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tant would communicate and maintain documentation with the appropriate staff and parents as well as maintain communication with teachers and parents to support the outcomes of the intervention.

Another option is to provide direct consultation services to the program staff. This can take the form of regular reflective supervision with the staff members who have direct contact with children and families, or supervision of the supervisors, strengthening their ability to provide support and technical expertise to their staff. Within this context, challenging classroom interactions or difficult family situations can be discussed in depth. In this model, the primary focus is on providing training to staff rather than clinical services to the children and families.

Staff members who are trained to conduct developmental screenings and psychological assessments and to create developmental plans also provide valuable consultative services in Early Head Start and Head Start programs. Through the use of insights gained through formal and informal assessments, staff and parents can develop a deeper understanding of their child's behavior and needs.

Collaborations with local agencies, clinics, hospitals, and universities providing services to the Early Head Start and Head Start population can be formed or expanded. Students being trained as professionals within the variety of disciplines that make up infant and preschool mental health can be a valuable source of providing counseling services and playgroups as well as formal assessments.

As you design or make improvements to your IMH program keep the following in mind—

- The design must fit the strengths and needs of the children and families.
- The program's resources must be able to support the design or outside resources should be cultivated.
- Contracted services are only as good as the contract's content.
- Communication is vitally important to the success of the program. Paraprofessionals and professionals involved must have a piece of the family picture.

Integrating infant mental health practices into programs does not mean that everyone must now become a psychotherapist.

These are exciting times for families and those of us who work with them. Programs that invest in knowledge and skill development will yield priceless dividends for both families and staff. Our goal is to regard every infant and family with respect, consideration, and empathy to better support their loving and attuned relationships.

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RELATIONSHIP AS CURRICULUM

"Child care must be understood as a profound influence on the lives of children, not as a service to parents like ATM machines." Dr. Gil Foley, Ed.D.

by LINDA LLOYD-JONES

At the Zero to Three National Training Institute in Washington, D.C. in December 2000, Dr. Gil Foley suggested that we are engaged in a vast social experiment—the venue and style of child rearing are being dramatically altered. For the first time, large numbers of children are being cared for by non-family members who have a professional rather than personal investment in them. Millions of babies are now in child care, some for 50 hours a week or more. How do we as early childhood professionals provide care for young children that meets their most basic human needs?

Regardless of the setting, the experts agree that the primary need of infants and toddlers is emotional connection. Relationships are the key and emotional development is the critical domain. As Dr. Foley said, "Child care must be organized to protect, sustain, and support emotional development. What is most at risk for children in care outside the home is the development of the capacity for relationships and endeavoring sense of inner security and spark of self that are spawned in relationships."

Young children's primary need is emotional connection

Photography by Indiantown MHS

This view is also expressed in the current report, *From Neurons to Neighborhoods*. In the executive summary, we learn that research has "generated a much deeper appreciation of the emotional role of early relationships as a source of either support and adaptation or risk and dysfunction. Complex emotions have powerful capabilities for the development of the essential social skills during the earliest years of life." Given the essential nature of deep emotional relatedness, how are we to capture these most profound and formative human experiences of infancy and toddlerhood in the context of a curriculum?

What does curriculum mean? According to the Head Start Program Performance Standards, curriculum is a written plan that indicates goals for children's development and learning, the experiences through which they will achieve these goals, how staff and parents will help them achieve these goals, and the materials that are needed to support these goals.

The needs of babies in group care are the same as those of babies at home—a safe, secure, and predictable environment; routines that are dictated by their own unique patterns and rhythms; and the presence of a primary caregiver who loves them. This caregiver needs to be attuned to the baby and able to recognize the baby's signals and respond appropriately. These are aspects of a good home environment that group care should replicate. As Dr. Foley put it, "The environment itself should be as home-like as possible. It should be designed to be nurturing and informal, in support of the experiences and interactions between children, caregivers, and families."

A misconception about the use of a written curriculum for infant/toddler care is that it will lead to the notion that quality care should be based on a school model rather than a home model. There is a certain pressure to define quality care as skills based and focused on cognitive development. Existing curricula look at infant/toddler development in separate domains (cognitive, gross motor, fine motor, language, and social-emotional)

and set goals and objectives for babies in each of these domains. But, a rigid, fragmented perspective to infant/toddler curricula is not in the spirit of the Performance Standards. The standards clearly indicate that social and emotional development is to be encouraged by—

- enhancing each child's individual strengths;
- providing a setting that allows for building trust;
- fostering independence;
- having realistic expectations;
- encouraging respect for feelings and for the rights of others;
- supporting and respecting a child's home language and culture; and
- planning routines and transitions so that they occur in a timely, predictable, and unrushed manner, according to each child's needs. *(See Performance Standard 1304.21 [A] [3].)*

Photography by Eyewire

Children develop their sense of self from their caregivers

These mandates enumerated in the Performance Standards cannot truly be accomplished in any other way but within the context of a relationship attuned to the individual child.

Babies in group care live there. They live with caregivers and other babies and children while their parents are temporarily away. When looking at what constitutes quality care for infants and toddlers, think of it in terms of quality of life. What are the minute-by-minute, day-to-day experiences of babies in care and how does this stack up against a "good natural home environment?" One feature that distinguishes home from school is that the home does not have a rigid set of activities. Even though home has basic routines and predictability, in between the necessary daily activities that families engage in are long leisurely periods when people do the activities that reflect their priorities within the protective shelter of love.

The strong and secure attachment that infants and toddlers need to share with their primary caregivers is described as a secure home base by noted child psychoanalyst, Margaret Mahler (1975). From this home base, infants and toddlers can venture out to explore their environments, engage with others, experiment, and problem solve. This secure home base, where children can relate to and connect with their primary caregiver as they need, has to be the central focus of any curriculum. It is through and in the context of relationships that infants and toddlers learn how to be in the world.

According to research described by Dr. Ronald Lally (1997), an Early Head Start collaborator in the Program for Infants and Caregivers, infants and toddlers develop their sense of who they are from the adults who care for them. They learn from their caregivers what to fear, what behaviors are appropriate, and how their communications are received and acted upon. They learn how successful they are at getting their needs met by others, what emotions and intensity levels of emotions to safely display, and how interesting others find them. None of these can be taught with a narrow focus on the behavioral aspects of curriculum, but are learned through awareness in relationships.

Children everywhere are becoming themselves and experiencing their feelings in increasingly complex ways during infancy and toddlerhood. Identity formations occur and it is the relationship with babies rather than the activities planned for them that profoundly affects the child's sense of self and emotional development. Beneficial environments, high quality toys and equipment, and a variety of developmentally appropriate activities are, of course, desirable in infant and toddler care. But, the only indispensable aspect of quality care is the relationship between babies and their caregivers. All the activities and materials in the world will not make up for the lack of bonded, loving relationships.

"Don't just do something, stand there and pay attention." Jeree Pawl

So what should be done to ensure quality of care? One idea is to expand the focus on curriculum for babies to include a curriculum for grown-ups. Dr. Lally has provided curricula for training staff that focus on helping caregivers develop attachments with babies. This program emphasizes watching, asking, and adapting as the steps to follow when interacting with infants and toddlers.

A curriculum will set goals and objectives for adults who care for babies. For example, one goal may be that caregivers will learn and demonstrate skills that promote children's curiosity. The effects will be seen in the happy, well-adjusted, and active children who feel free to explore their environment. Helping caregivers learn to engage in authentic, deep, loving relationships with infants and toddlers is something that must be done for the long-term benefit of social and emotional competence.

We need to turn caregivers' attention away from planning what babies *will* do all day in care and onto what their babies *are* actually doing all day. Noted infant specialist Jeree Pawl (1998) offers this wise advice, "Don't just do something, stand there and pay attention." We should watch and observe our babies much more closely. What are they doing? How are they playing? What are they trying to achieve? Ask them who they are, what they need, how they can be helped. Then listen and watch for the answer and let that guide what we choose to do with our babies. In this way the baby will truly direct his or her care. The baby will lead.

This is hard work for caregivers. To truly attend to and "be there" emotionally for babies is not a skill, but a way of being. Engaging in loving, responsive relationships with each individual baby while at the same time fully supporting the family/child relationship is a tall order. It requires that caregivers have a depth and breadth of knowledge about infant and toddler development; a high degree of self-awareness; a wellspring of emotional resources; and intense dedication to the well-being of other people's children. As a society we do not yet sufficiently value the people who take on this responsibility, nor do we give them the support they need. This is an area where Head Start and Early Head Start can take the lead as a national laboratory for best practice.

Alison Clarke-Steward (1993) stated that one of the primary goals for child care is to facilitate a happy childhood. When we focus fully on training and supporting caregivers to love their babies and be responsive to their needs, this will allow for the optimal expression of each infant's needs and abilities in a curriculum. Babies in the hearts and hands of such caregivers have a real chance for a happy childhood and the development of social and emotional competence. Loving, responsive, and well-trained caregivers will know how to meet their babies' needs because they will listen to what their babies are telling them and respond from the heart.

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DAILY SEPARATIONS AND REUNIONS

Daily separations and reunions are part of the fabric of relationships. In center-based programs, they provide opportunities to develop a young child's skill at making positive transitions. by [redacted]

FROM BIRTH, POSITIVE GIVE AND TAKE in relationships fosters social and emotional well-being and resilience. Secure relationships are particularly important for a very young child's language development, problem solving, social interaction, and emotional regulation. The patterns of interpersonal exchanges during the early years have significance for the developing brain, including the development of a young child's sense of self, as well as what the child thinks, remembers, and feels. Researchers have found that although brains are impressive in their continuing ability to change and adapt throughout the life cycle, early relationships are significant in influencing future development.

Photography by Eyewire

Relationships described as "secure attachments" involve identifying and enhancing positive emotional states such as joy and elation and identifying and supporting painful emotional states such as fear, sadness, and anger. Hellos and goodbyes—times when young children's emotions are often heightened—provide golden opportunities to build and enhance relationships. It is important to take into account the reality that parents and professionals often experience intense emotions themselves and are influenced by their past experience with comings and goings from loved ones.

In Early Head Start and Head Start center-based programs, reunions and separations happen simultaneously. Every morning, young children separate from their parent and reunite with their teacher. Every evening, young children separate from their teacher and reunite with their parent. Since the mental health of young children depends on the emotional well-being of the adults who care for them, providing support for the adults is equally as important as providing support for the children.

The pattern of give and take that occurs among young children and their parents and teachers shapes how children feel about themselves. Both infants and adults contribute to the quality of the relationship. Some patterns lead to a child's sense of safety and well-being. For example, an adult who generally responds to the specific emotions and non-verbal requests of an infant by remaining emotionally present and focused while not being intrusive helps a child to feel noticed and valued. As infants grow older, their contributions evolve from non-verbal signals to a mixture of non-verbal and verbal signals as the adults' verbal responses become more detailed.

Misunderstandings are inevitable in the course of the normal give and take between young children and adults. The key component in secure relationships is the ability to repair a misunderstanding. For example, when a mother realizes that her nine-month-old is fussy because he wants her to look at the light on the ceiling, not at the toy on the shelf, she will be rewarded by a delighted smile and squeal as she redirects her attention to the light, smiles, and begins to talk about it with him.

How children express emotion during hellos and goodbyes evolves with age and with their length of time in a program. A newly enrolled three-month-old baby rarely says goodbye in a pronounced way; however, she might withdraw or take time to observe another baby rather than engage with a toy or person. This apparent lack of response may be difficult for some parents to understand. Loud protests are taken as a more common sign of connection.

Older infants (six to nine months of age), toddlers, and preschoolers might say goodbye with cries of protest when they begin a new program or they might walk in with a smile and a wave goodbye. Each response merits the teacher's and parent's acknowledgement and affirmation.

Separations and reunions are stressful for the adult, especially at the beginning of a relationship. Acknowledging the adult's emotions, whatever they might be, mitigates the stress. Supervisors and peers can provide this for the teacher and the teacher can support the parent, as can other parents. A parent's feelings might range from sadness and fear about separating to relief and elation about having time away.

Saying goodbye to a crying or withdrawn child might make a parent sad. Finding and talking to another parent in the hall who is also feeling sad or finding it hard to say goodbye can be comforting. At other times the educational coordinator or site manager might be the right person to chat with for a few moments.

Staff members generally report that by the end of the first month in a center-based program, even young infants look to the teacher for comfort and stimulation and indicate preferences through calling to, looking at, and wriggling with delight towards specific staff. Teachers are rewarded by these interactions and by their ability to comfort a crying child. However, some children who are temperamentally slow to warm up may not demonstrate delight for a long period of time. They also may be quick to cry when they are getting to know a new person. Supervisors and peers can support the teachers through this process by acknowledging their feelings of frustration or anxiety.

Over time, young children begin to express joy in reunions with their teacher. How staff and parents interact can support the well-being of the adults as well as the child. When nine-month-old Leah leans out of her mother's arms with a broad smile on her face and eagerly goes to the teacher in the morning, her mother smiles warmly and says, "Oh, you are happy to see Sarah." Many mothers appreciate the pleasure their children experience in their expanding social world. However, some parents might feel concerned or anxious about whether their baby still loves them.

The teacher can have a pivotal role in reassuring the parent that the baby has room for more than one significant relationship and keeps each person "straight" in his or her own mind. The teacher can point out how the baby might wriggle or crawl towards the parent when he arrives, or help a parent understand that an older child might need time to reconnect through playing or reading a book before going home.

Infants, toddlers, and young children may cry when they separate from their parent. At times the separation from the parent may not be done in an optimal way and even exacerbate the child's distress. Here is an example of how a teacher in Early Head Start responded to the distress of a young child in a way that built her relationship with the toddler and her parent and affirmed the child's relationship to both adults.

Darlene, two years of age, bundled up in a snowsuit, hat, and scarf, arrives crying at the gate to the infant/toddler room in the arms of her mother. The mother, in a rush that morning, hands Darlene to a teacher standing at the other side of the gate. The mother dashes off after quickly saying goodbye.

TIPS FOR PROGRAMS

Supporting emotionally meaningful separations and reunions

- Provide parents with access to staff after saying goodbye to their children. If a baby was crying when the parent left, the parent might be comforted by talking to the teacher or the director and hearing how the baby is doing.
- Spending time in the morning observing the classroom can give the parent a concrete image of other babies in the arms of caregivers singing and talking and reminding the babies that "mama or dada will be back later."
- Create a welcoming environment for parents so that they can enter the room, help children get settled, connect with a teacher, and hang out at the end of day. These moments allow the staff and parents to interact and share their feelings and knowledge of the child.
- Arrange for and invite parents to regular (monthly) parent/staff meetings to talk about their children and hear how other parents and children are doing.
- Provide regular, reflective supervision so staff can discuss their emotions and responses to children and parents.

With preschool children, we might begin to wish they would not cry or cling and we might see the tears as a failure rather than as an opportunity for connection.

The teacher says, "Goodbye, see you later." The teacher brings the child to a cozy corner with large animals. Darlene stays in the teacher's arms and sobs. The teacher talks to her gently saying, "It's okay, mommy will be back after work." The teacher's first overture to take off Darlene's hat and scarf are met with louder sobbing. The teacher holds Darlene and continues holding her, reassuring her that it is okay to feel sad and angry and reminding her that her favorite giraffe is waiting to play. Within a minute, Darlene's sobs begin to subside and she lets the teacher take off her hat, scarf, and snowsuit. Within the next minute, she is calm and explores a giraffe sitting next to the teacher.

Photography by Lynnane

With preschool children, we might begin to wish they would not cry or cling. We may see the tears as a failure rather than as an opportunity for connection. Parents and program staff struggle with fears that it may be "bad for the child" if we respond immediately to a crying child, especially a boy. In fact, boys, as well as girls, need to know that they can express their feelings, be comforted by caregivers, and develop their own coping mechanisms.

Whatever a child's emotional state might be, the quality of interaction between all the participants influences a child's sense of well-being when saying goodbye to a parent and hello to a teacher.

Susi, a little over three years of age, arrives walking and holding her father's hand. Susi and her father enter the room and the father greets the teachers. He kneels down and helps Susi take off her snowsuit, hat, and scarf, talking to her about what he is doing. A teacher comes over and talks to them and asks how Susi's morning was and the father describes what they ate. Susi stays close to her father as he hangs up her clothes and puts some things in her cubby. Susi observes what the teachers and other children are doing and smiles when a teacher invites her to come and sit and read a book with her and several other children. The father walks over with her and stays while she settles in and then says goodbye. Susi waves goodbye to her father and the teacher says, "Bye Dad, we will see you later." The father leaves and Susi sits close to the teacher, focusing on the pictures in the book. In a minute or two, Susi gets up and walks over to the housekeeping corner and begins "cooking" with a friend.

Although many parents and staff know that even young infants are aware of comings and goings, at times it still might be tempting to leave without saying goodbye—generally at a moment when the child is engaged in play or snuggling in the teacher's arms. The understandable goal is to prevent a child's protests and tears. However, the hidden cost is a missed opportunity for the child to develop the skills necessary for making positive transitions. Over time, adults' comforting helps children learn to comfort themselves.

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STRESS AND THE DEVELOPING BRAIN

Some people believe that babies and young children are not affected by events that take place when they are very young, but what we do in the first three years has a tremendous impact on children's future development. by BEVERLY GOULD

RECENT RESEARCH AND TECHNOLOGICAL ADVANCES have changed our understanding of the developing brain. With this new information, parents and educators have the opportunity to provide children with interactions and settings that will allow them to reach their greatest potential. We now have a greater appreciation for the fact that the early years are a very fertile period in the child's life. We need to make conscious choices about how we treat children so that impact can be positive.

Research has demonstrated that there is an interaction between one's genetic endowment (nature) and the environment (nurture). Structural, hormonal, and chemical influences that are present during pregnancy affect the growth and development of the fetus. As early as three weeks after conception, a baby's brain cells begin to form (Berg 1994). These nerve cells then migrate to sections of the brain that will eventually control the reflexes, voluntary body movement, perception, language and thought. These structural changes—the cellular linkages being made—are unique to each individual infant. The linkages form as a result of the infant's experiences, both in the womb and once they are born.

Playful give and take with a caregiver stimulates development

Photography by Evecare

Medical science continues to demonstrate the far-reaching harmful effects of stress. Stress is defined as an emotional reaction that elevates cognitive and physiological activity levels. It places demands upon the system for physical or cognitive productivity. When those demands are activated over a period of time, it progresses to a series of changes leading to exhaustion.

The degree of stress experienced by a woman while she is pregnant can have a negative affect on the fetus (Gunnar & Barr 1998). When maternal hormones, such as corticosterone and tryptophan, become overstimulated due to her own stressful conditions, there is a harmful chemical effect on the fetus' brain development.

The adult "fight or flight" response to stress is not an option for an infant or young child. Exposure to intense anger, loud screaming, or physical violence creates fear within the child that floods the brain with stress hormones. Being left alone and crying when hungry or wet are also conditions that create fear and stress in a young child. Various types of unpredictable, traumatic, chaotic, or neglectful environments physically change the brain by over-activating the neural pathways. As a result, there may be an increase in the child's muscle tone, profound sleep difficulties, an increased startle response, and significant anxiety. These responses, in turn, can lead to a permanent state of high alert, a tendency to misperceive the intentions and behavior of others, and the tendency to react with aggression.

Conscious memories of the first years of life are lost but the emotional part of the brain, referred to as the limbic system, and the body remember (Karr-Morse & Wiley 1997). An

infant's first sense of what the world is like is recorded in the body. Without intervention, young children who have experienced high levels of stress will be at serious risk for emotional, behavioral, and learning difficulties.

Early Learning

NEUROSCIENTIST DR. JAMES LEDOUX (1993) agrees that events early in life, experienced with strong emotions, can and do remain an influence throughout our lives. He suggests that what we feel is processed before what we think. Feelings experienced precognitively and preverbally continue to play out in later life even though the individual may have no conscious memory of the association. A significant trauma that takes place often or intensely enough can rob a child of the ability to learn normally by pulling away brain circuitry meant for other tasks.

Photography by Eyewire

An area of the brain, referred to as the amygdala, is central in understanding how stress affects learning. The amygdala governs attention, memory, planning, and behavior—all skills necessary for the child to be able to take in and process information. Difficulties in attention often include distractibility and impulsivity, which impair problem solving. In social situations, children who are overly active, impulsive, and unable to focus tend to have trouble reading others' social cues and responding appropriately to others in the environment.

Role of Relationships

RESEARCH LINKS THE EXTERNAL ENVIRONMENTAL influences on brain development with the quality of stimulation and degree to which the caregiver is attuned to the needs of the infant. Social interaction with an empathetic and attuned caregiver plays the major role in the growth and regulation of the child's nervous system and in helping the child develop the strength needed to become socially competent and able to learn. The consistent experience of empathy that takes place with an emotionally available caregiver gradually builds the child's capacity to empathize with others.

Relationships that a child experiences provide the foundations for approaches to learning, which, hopefully, will be enthusiastic, curious, and persistent. Stanley Greenspan (1997), a noted child psychiatrist, explains that the capacity to feel a full range of emotions—learned through relationships—allows children to organize events and ideas before they have the words to express them. Children learn how to think by creating ideas based on their experiences and how it feels to engage in those experiences. For example, young children become more focused and interactive through being able to enjoy the excitement of reciprocal play. The playful and creative give and take with an emotionally present, verbal adult motivates the development of language and encourages the child toward discriminating, generalizing, categorizing, and organizing her experiences. This is the basis for the ability to think first concretely and then abstractly.

The Abecedarian Project at the University of Alabama (Campbell & Ramey 1994) found that when at-risk young children were exposed to a stimulating environment, appropriate toys, playmates, and good nutrition, they developed less mental retardation than the control group. Early intervention in infancy, when the neurological circuits for learning are being formed, resulted in higher IQs in comparison to the control group. The conclusion was that early enrollment in a high quality, enriched day care setting is paramount to the children's significant and long-lasting improvements.

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online...For more information on Head Start, visit our site at <www2.acf.dhhs.gov/programs/hsb/>.

An intense trauma can rob a child of the ability to learn normally.

How Head Start Can Help

HEAD START IS IN A UNIQUE POSITION to assist in healthy brain development.

- Through services to pregnant women, expectant mothers can be helped to receive pre-natal care, get adequate nutrition, and be educated about the dangerous effects that drugs and alcohol have on the developing fetus. During pregnancy, families can be helped to identify areas of stress and provided with the necessary emotional support and assistance.
- Parents need to be educated about the child's need for appropriate stimulation. As caregivers learn to read the child's cues, undue stress can be avoided. Parents need to understand the importance of talking and reading to the child, holding a child during feedings, making eye contact, singing, and playing games that provide novelty and fun.
- Parents also need to be supported in maintaining their own mental health. Untreated depression and anxiety interferes with the parent/child bond and interrupts a parent's ability to be fully aware of the child's needs.
- Abuse, neglect, and family violence must be prevented. The population at large needs to be aware of the devastating impact these things have on growing children.

In addition to the developmental assessments required by the Head Start Program Performance Standards, an assessment of the interaction between the caregiver and the child can identify relationship issues that might need mental health intervention. The ability of caring and well-informed Head Start staff to recognize problems early can prevent difficulties that would be much more difficult to remedy later.

Classroom teachers and home visitors play a crucial role in optimizing healthy brain development. Infant researcher Ron Lally (1995) points out the key role the infant/toddler caregiver plays in the development of the child's sense of identity. Through imitation and absorption of the environment, children form their sense of who they are in the world. Helen Raikes (1993) cited the importance that a relationship between a child and a high quality teacher plays in "modulating attention, creating interest, building trust, and assuring predictability for the infants." This is especially true when the child is given the time needed with one teacher, as opposed to multiple interactions from a variety of caregivers. The time spent building this attachment allows the teacher to fine-tune her interactions based on her intimate knowledge of the individual child and his needs and responses. Both parents and children can be supported in Head Start to minimize stressful situations that impede healthy development.

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THE PSYCHOLOGICAL WORK OF PREGNANCY

THE HEAD START PROGRAM Performance Standards mandate that family and health care providers offer services for pregnant women that address both physical and mental health needs. Head Start is in a position to provide invaluable support to expectant and new mothers. This article will explore some of the emotional needs of mothers and discuss areas for fruitful exploration and intervention to help in that process.

Pregnancy ushers in a tremendous physical and psychological transformation. Besides the bodily changes, there are disruptions in basic physiological processes that affect sleep, appetite, and digestion. Hormonal surges can affect mood and the ability to think and to remember. There are also intensely ambivalent emotions and fantasies about the process of labor and delivery.

A woman also experiences changes in her sense of self. She has to expand her sense of who she is to incorporate her child as a part of herself, yet also as a separate being. The appearance of a child will change her intimate relationships, such as with extended family members, as well as her role in society.

Mental Work and Reworking

IN LOOKING AT THE PERIOD SURROUNDING a woman's giving birth, Daniel Stern (1995) described this as a time when she must engage in the greatest amount of "mental work and reworking" in her life. He says that this is especially true for the birth of the first child since no amount of babysitting or exposure to siblings can prepare a woman for the intense empathic connection needed to mother successfully a child. There is no other activity in a woman's life that will require her full emotional presence and involvement as much as raising a child. Stern identifies four concerns that preoccupy the expectant mother.

First, the expectant mother is afraid of not being able to maintain the baby's life. She has fears for her own and the new baby's survival. Once the child is born, she wonders if she will be able to provide the care that will allow the infant to grow, progress, and thrive. She is very vulnerable to the criticism and judgment of others. Society expects the birth of a new baby to be a happy time. For many women, even those who are in the most supportive circumstances, it is conflictual and stressful.

Second, the expectant mother wonders if she will really be able to feel love for her baby. Will she feel the bond that society says she is supposed to feel? Will that bond allow her to develop the special sensitivity that will allow her to read and respond to her baby's needs?

The next concern is the expectant mother's ability to create and maintain an adequate support network for herself. There are no societal structures that function in place of the extended family. As a result, there is greater stress on the father, if he is present, to provide the emotional support so that the mother will be able to devote herself to the child. Stern sees inherent dangers for a mother who has a limited support network and

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PUTTING THIS TO WORK IN YOUR CENTER

Steps that programs can take to promote the mental health of new mothers and fathers—

- ✓ Form support groups for pregnant women to share fears and expectations and educate them about pregnancy, childbirth, and child development;
- ✓ Form activity groups like knitting or craft groups as a vehicle for support and discussion;
- ✓ Pair young mothers with older, more experienced mothers as mentors;
- ✓ Form support groups for fathers;
- ✓ Form mother/baby and father/baby groups to encourage responsive interactions and reciprocal play;
- ✓ Use videotapes as a tool in teaching how to respond to an infant's cues;
- ✓ Provide anticipatory guidance showing new parents what to expect at each phase of development;
- ✓ Explore in depth the themes described in this article with both parents, whether or not they are together

therefore, limited sources for feedback, information, and emotional support. She may be seen as an inadequate mother by the father or the extended family; the father may compete with the baby for her attention; or the father may compete with her to be the "better" parent.

A new mother may fear emotional as well as physical abandonment. In the past, a supportive network of women who surrounded the mother and baby, keeping males outside of the protective circle, used to be something that all women could rely upon. Besides her baby, the new mother's major involvement

Six-month-old James Mathews Jr.

Photography by EHS NRC

would have been with these maternal figures.

A new mother also reflects on her relationship to her own mother. This allows her to remember the intricacies of this first important relationship, and to form either positive or negative models of parenting to guide her own behavior.

The fourth concern deals with a woman's need to rework her sense of identity from "daughter to mother, companion to parent." A preoccupation with the memories and emotions connected to the long line of women throughout the family history causes a woman to reconsider her beliefs and her choices. Stern says that this is how the intergenerational transmission of family values and behaviors occurs.

Babies cannot wait. During their waking hours, the mother must be able to set aside her own preoccupations and concerns so that she can be attuned to her child's needs. The work of Selma Fraiberg (1980) and other infant researchers tells us that an infant stirs up many intense, raw emotions that reflect the mother's unresolved conflicts with her own mother and father.

Reviving Old Patterns

THESE "GHOSTS" FROM THE MOTHER'S PAST can have an enormous impact on her entire pregnancy experience and on her ability to connect to her child. Simply having mixed feelings about being a mother can raise significant conflict and guilt for women who are not comfortable accepting emotions typically seen as negative. For example, a woman may expect her child to be active and controlling, as her own mother always described her and this would influence the way she perceives the needs and behaviors of her child. The key for a healthy relationship between mother and child is for the mother to be consciously aware of the issues between her and her mother, thereby avoiding displaced anger or feelings of abandonment or loss. This will help her not to be preoccupied with winning or avoiding power struggles as they arise with her young child.

For those women who have had significant difficulties growing up or have been the victims of trauma or abuse, it is important to help them identify the good qualities of their mother among the difficult memories of their early lives. The demands of being in the mothering role can be a terrifying experience for women unable to resolve a deep-seated belief in their own "badness" or fear of "turning into their mother." Attempting to relate to a helpless, crying, demanding, and dependent infant can trigger old patterns of behavior from the mother's childhood where she was perceived negatively because of her own mother's unmet needs and psychological difficulties. Without awareness of her past and the feelings associated with the trauma or abuse, she may in fact treat her child the way she was treated rather than in a more healthy, protective, and nurturing fashion.

Family Dynamics

A NEW BABY ALSO CHANGES THE DYNAMICS between the couple and within the nuclear family. The father experiences a significant change in role and identity. In today's western culture, a father's role is more than financial; men are expected to take on increas-

ing amounts of responsibility for the child's emotional and physical care. A man may feel ambivalence about the changes in his partner. He may also feel abandoned and excluded as the woman turns her attention to her pregnancy and new baby. On the mother's part, it may not be easy to share caretaking with the father since it has traditionally been the domain of women. Without awareness, issues of power and control may arise. As the partners move from being a couple to a family, all decisions will need to consider the needs and the role of the child.

Emotional Stress and the Infant

CURRENT RESEARCH, particularly the work of Megan Gunnar (1998), demonstrates the negative effects that emotional stress has on the developing fetus. Those who provide services to pregnant women and their families need to help expectant parents talk openly and fully about positive and negative feelings associated with pregnancy and their role as parents, including fears about the pain of childbirth. They need to explore how the new child will affect their relationship with extended family and discuss boundary issues that may arise if a family member is perceived as too helpful, too distant, or too critical. Important discussions can occur about the values that each parent holds, such as around discipline or religious matters. Older siblings also need to be prepared for the new baby and helped to deal with the anxious and jealous feelings before and after the birth.

Women need to be educated about maternal depression and its consequences for the development of their child. Support groups for pregnant women, a doula (a labor and post-childbirth support person), non-medical childbirth coaching, mother/baby groups, and father/baby groups can be useful in providing the needed support and in assessing potential difficulties. Pairing more experienced mothers with new, young mothers who can mentor and be positive role models may also be useful.

Teaching parents about the stages of development allows them to anticipate the joys and challenges that they will face as their child grows. In those situations where the mother's emotional difficulties require more than community support, or a child's temperamental or constitutional factors lead to a difficult fit between parent and child, referrals to early intervention or qualified infant mental health practitioners can be necessary.

Helping our Head Start families become emotionally prepared during pregnancy can go a long way in preventing emotional difficulties after the baby is born. We know that times of change can bring great opportunities. The birth of a new baby should be a joyful time. For many of our families who have severe external stressors, such as financial difficulties, young or unwanted pregnancies, traumatic abuse, or substance abuse histories, this is a time when our active intervention can open up unseen possibilities and provide much needed insight and support.

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Head Start Program Performance Standard 1304.40c iii

Early Head Start grantee and delegate agencies must assist pregnant women to access comprehensive prenatal and postpartum care, through referrals, immediately after enrollment in the program. This care must include mental health interventions and follow-up, including substance abuse prevention and treatment services, as needed.

BUFFERING THE EFFECTS OF MATERNAL DEPRESSION*

Did you know approximately one in ten women with young children experience depression? Rates often reach two times this level for mothers living in poverty. Depression is likely to touch someone in our lives as well in as the lives of the families we serve. by [illegible]

FORTUNATELY, SOME CHILDREN escape the negative effects of maternal depression. In a review of several decades of research, Shonkoff and Phillips (2000) emphasize that many depressed women do raise children who demonstrate no social or behavioral difficulties. Some studies suggest ways to prevent or protect damaging processes from occurring in young children's lives. Early Head Start and Head Start programs are in a position to benefit from this research and intervene to support young children and their parents who might be experiencing depression. Their intervention efforts can be guided by research findings related to the complexity of maternal depression, the effects of maternal depression on young children, and the importance of prevention and early intervention.

The Complexity of Maternal Depression

DEPRESSED MOTHERS TYPICALLY have difficulty providing optimal levels of stimulation for their babies. Mothers who suffer from untreated depression engage in two distinctive interaction styles with their infants (Field 2000). One style is characterized by the caregiver's withdrawal from the infant's cries or smiles, minimal display of facial expression, and difficulty expressing emotion or even talking to the infant. The other style is characterized by the caregiver's irritability, expressions of anger, and demands for a reaction from the child. It is unclear as to why mothers with depression display these differing interaction profiles; one, withdrawn, the other, intrusive. But, it is clear that each style is painful for the adult. One mother described the feeling of "moving through water" to reach her crying infant.

Effects on Young Children

RESEARCH SUGGESTS THAT EACH MOTHER/CHILD interaction style has different effects on the infant or young child (Field 2000). Infants of withdrawn mothers display low activity levels, inattentiveness to people, activities, and objects, and low expressiveness in response to the facial expressions of adults. In contrast, infants of intrusive mothers display higher activity levels, a mix of positive and negative facial expressions, and high attentiveness and expressiveness in response to the facial expressions of adults. Preschoolage children of withdrawn mothers appear less socially responsive, less able to regulate their own behavior and impulses, and more inhibited. They also show internalizing behaviors, such as liking to be alone. In contrast, preschoolers of intrusive mothers are more responsive, more able to regulate their behaviors, and less inhibited. Furthermore, they are likely to show externalizing behaviors, such as getting in fights and teasing others.

The Importance of Prevention and Early Intervention

EVEN THOUGH MATERNAL DEPRESSION may have negative developmental outcomes for children from a wide range of life circumstances and family environments, certain factors serve to minimize, or buffer, the effects of maternal depression on young children. For instance, research by Hossain and colleagues (1995) shows that involved, supportive, and emotionally healthy fathers and child care providers cushion children from negative effects of maternal depression.

In addition, when maternal depression occurs in a family experiencing marital harmony, mothers are better able to sustain positive and healthy interactions with their children. In turn, the children are more likely to display sound social-emotional behaviors. Recent studies also suggest that depressed mothers who use excessive verbal stimulation with their infants may actually facilitate better cognitive and language development. Understimulation may be worse than overstimulation during infancy. Furthermore, since the effects of maternal depression begin as early as pregnancy and appear to be long lasting, findings emphasize the importance of early intervention.

Implications for Programs

ONE OF THE PRIMARY GOALS of Early Head Start is to enhance

infants' and toddlers' overall social, emotional, physical, cognitive, and linguistic development. Therefore, it is vital that Early Head Start as well as other Head Start programs promote the physical and mental health of mothers. Programs are in a unique position to support the mental health of pregnant women and mothers, but must be sensitive to the barriers depressed parents experience in receiving services.

Depression makes it difficult to mobilize and focus energy. Many parents experience shame and fear that professionals might see them as incapable of parenting. However, given that parents love their children, the birth of a child can provide the impetus to seek services to provide a better life for the new son or daughter. In addition to benefiting from the direct support and therapy offered them, depressed parents are reassured knowing that their infants and toddlers are receiving nurturance and support within center-based or family child care programs.

By looking for brief moments of positive interaction and reflecting on them with a parent, program staff help build the parent's confidence. Low self-esteem often accompanies depression and the home visitor and center-based teacher can provide positive images and reinforcement. For example, a home visitor could support a depressed mother with a more demanding interaction style by noting when the mother takes turns vocalizing with her baby and admiring the interactions when they occur. Or, a teacher working with a depressed mother with more withdrawn interactions could highlight when the parent smiles or talks in a lively way with the child.

Providing staff with access to mental health consultation can support timely and effective referral to mental health services. Regular, consistent mental health consultation services are key for supporting staff and families and can help distinguish the parent's or staff member's normal emotional ups and downs of life from clinical depression. A skilled mental health consultant can help staff find ways to connect with a depressed parent as well as support them through the parent's potential resistance to getting help. Furthermore, the mental health consultant acknowledges that staff and parents approach the issue of depression, or mental health, from their own beliefs, values, and family history with mental health services.

ADDRESSING MATERNAL DEPRESSION

Questions that programs could ask themselves

- What is the understanding of program staff around issues related to maternal depression?
- What is the understanding of program staff about the mental health of primary and other significant caregivers for the well-being of infants and young children?
- How does the Family Partnership Agreement include issues related to mental health?
- Do the mental health consultants train program staff to recognize symptoms of depression in mothers or other primary caregivers of young children?
- Do mental health consultants suggest strategies to program staff that correspond with the mother/child interaction profile?

* *The research discussed within this article is specific to mothers with depression. However, the mental health of the primary and other significant caregivers is important for the well-being of infants and young children.*

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CHALLENGING BEHAVIORS IN THE CLASSROOM

What kind of challenging behavior can cause well-meaning programs to reject a child still in diapers? by ALICE EBERKARDY-WRIGHT

MY MOTHER STARTED A CHILD CARE CENTER when my little brother was four years old and I was seven. She taught for 20 years and by the time I began studying formal child development ten years later, I had spent time with hundreds of children ranging in age from three to six. Yet with all my mother's skill, she found that some children were not in the textbooks: children who had internal rages, who attacked, who destroyed, or who had vulnerabilities that rendered them out of control.

Research indicates that the number, nature, and severity of disruptive behavior problems are increasing. By three years of age, children are capable of inflicting great bodily harm on others. I have met a number of families whose children have been expelled from child care homes and centers before their third birthdays. In my work with Head Start and Early Head Start, I have consulted with a number of programs that have been overwhelmed by having as many as three of these children in a classroom of eight. We must ask ourselves several questions. First, what can cause well meaning programs to reject a child still in diapers? Second, what caused the child's problem in the first place? Third, what can and should Head Start programs do to resolve these problems?

Signals for Help

THESE CHILDREN are easy to spot in a classroom, at home, or in public. They bite, hit, destroy, and erupt like volcanoes on a regular basis. Unlike many young children who may do these things occasionally or even during a fairly intense stage that may last a few weeks or months, these children feel overwhelmingly difficult to those dealing with them. They are unpredictable, difficult to channel into other activities, and almost impossible to calm down once they act up. Usually they show no remorse or guilt, and discipline strategies such as time-outs are often ineffective. The child that sent me scurrying from my mother's child care center into mental health training walked around saying that he could kill. He stabbed another three-year-old in the neck with a pencil. Two-year-old Danny at my own therapeutic preschool reportedly tore his crib sheets into shreds at six months old and was a perpetual biting machine who called himself, "Me Bad Teeth." Four-year-old Henry dismantled everything from doorknobs to cubbies at his day care center. Sent to mental health clinics, children like these may receive diagnoses of Attention-deficit/Hyperactivity Disorder (ADHD) or Oppositional Deviant Disorder (ODD).

What are the Origins of these Behaviors?

THERE IS NO SIMPLE ANSWER, and people in the field must be like detectives, realizing that the story is different for every child.

The origin may have a biological base, with brain make-up being the root of the difficulty. Babies may come into the world with a regulatory disorder. These atypical physiological, sensory, attention-related, motor, or affective processes can seriously affect a child's behavior. Chemical addictions that pass through a placenta to a fetus may affect some babies. Chronic mental illness inherited from parents and extended family members may start to show up at young ages.

The relationship between parent and child is critical. Attachment problems, temperament/personality conflicts between parent and child, maltreatment, developmentally inappropriate discipline, and inconsistent and insensitive parenting all call for attention and intervention within the relationship.

Life events can determine out-of-control behavior. Juggling between multiple caregivers, crowded, unresponsive child care arrangements, and exposure to traumatic events all take their toll with some children. Our society is particularly difficult for children with its frightening violence, premature sexuality, exposure to over-stimulating, inappropriate media, substance abuse epidemics, and overwhelmed, fragmented families.

Helping to Regulate the Uncontrolled Child

HEAD START'S POLICY IS TO WORK WITH the neediest of the needy, to pioneer new strategies for challenges faced by young children and program staff, and to embrace parents and community partners in the work. Head Start institutes and builds training for teachers, caregivers, and family advocates to suc-

ceed rather than give up. The central focus is always what it will take to help that child be successful.

Information contained in the Head Start Program Performance Standards, Zero to Three publications, and training guides are good general resources. Parents and community partners (Part C and Part B, mental health consultants, pediatricians, and social service agencies) are critical, and the national and regional Head Start training and technical assistance contractors are on board to help find solutions. All of us are gaining more expertise at surfing the Internet.

Besides these formal resources, I suggest the following practical advice.

1. Find someone to provide one-on-one shadowing. I tell volunteers, trainees, or assigned staff to velcro themselves to that child and learn to predict and prevent disruptive behavior. If one child is about to hurl a block at another, the assigned adult should firmly but gently help the child place it down with appropriate words such as, "Blocks can hurt. This one belongs right here." If more than one person provides the support, assign people in a predictable, consistent way so that the child can build relationships and experience stability.
2. Help staff and parents be creative, first understanding the probable reason for the child's out-of-control behavior and then planning appropriate intervention. Example: Henry used to dismantled everything because his psychotic father threatened to tear the children apart limb by limb if they got off the couch or out of bed. Intervention included getting the father into treatment and on medication and finding a toolkit for Henry to use to dismantle appropriate items to his heart's content.
3. Provide staff with consistent mental health consultation, instructive and experiential training, and weekly supervision when they are handling difficult situations. A wonderful child psychiatrist met with my staff for several hours weekly on a regular basis to understand behavior, to plan, and to evaluate effectiveness. If a number of primary caregivers, especially parents, are involved with a child, the communication and planning needs to include all of them. The more the child experiences loving, firm, and consistent care, the more effective the intervention will be.
4. Provide a combination of behavioral controls and reasonable consequences; well-trained, consistent staff; facilities that offer quiet spaces and comfort; activities that permit out-of-control children to work through difficult feelings; and a psychiatric recommendation for medication reserved only for older preschool children who require more than tight structure.

Photography by HSNRC Photo Archive

Regular communication and planning with parents and other primary caregivers are generally the formula that leads to success. With everything in place, I have seen very challenging children transform themselves into socially successful children who are ready to learn over the course of a year.

As early childhood educators, we are remarkably creative and innovative. If we allow ourselves to really feel and understand, we may receive the gift of effective intervention with the tools of our trade.

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BY KATY BEH NEAS

STRATEGIES OF BEHAVIOR
MANAGEMENT FOR SPECIAL NEEDS CHILDREN

EASTER SEALS NORTH GEORGIA, a Head Start grantee, is succeeding in implementing positive behavior management strategies for enrolled children, including children with special needs. Approximately ten percent of the enrolled children have special needs, ranging from mental health and behavior management issues to speech delays and physical impairments.

Donna Davidson, President of Easter Seals, and Diana Makombe, Head Start Disability Specialist, have provided one-on-one training for the classroom teachers who are serving children with special needs. This training has enabled the staff to appropriately meet the needs of all the children. Staff has noted that the children without disabilities provide invaluable assistance to the children with special needs. The stories below demonstrate the benefits and value of inclusion.

Photography by Indiantown MHS

Teachers use positive behavior management strategies to serve children with special needs

GREG, a three-year-old who attends the Easter Seals program, was diagnosed with autism shortly after enrollment. Greg did not have any expressive language and had a great deal of difficulty with his receptive language skills. He was not toilet trained and engaged in many repetitive behaviors. Easter Seals worked with the local education agency to develop an Individualized Education Program (IEP) as required by the Head Start Program Performance Standards. Greg's IEP focused on increasing his language, self-help, and socialization skills and decreasing his inappropriate behaviors. Staff worked closely with the school district in planning individualized lessons for Greg and in assessing his progress.

Like many other children at Easter Seals, Greg now attends a special needs preschool program operated by the public schools for two and a half hours per day. The remainder of the day, he is in the Easter Seals Head Start Program.

Greg has made wonderful progress as a result of this cooperative partnership. He is using single words to greet and request. Easter Seals Head Start provides an inclusive setting that has helped him increase his socialization skills with his peers. He is beginning to play with the other children. He actively participates in group activities and his repetitive behaviors have decreased. He has also been successful in improving his self-help skills, particularly toileting.

EROS is another success story. Eros, who has Down Syndrome, is a bilingual, three-year-old child attending Easter Seals and the public schools. In addition to his developmental disabilities, Eros displayed aggressive behaviors such as hitting, scratching, and pulling the other children in the classroom. He often tried to leave the classroom.

Easter Seals worked closely with the local school district to develop goals and objectives to manage these behaviors. Eros responded to a fixed schedule with set routines and clear expectations. Redirection to deal with his aggressive behaviors has proven successful.

The teachers also educated the other children about Eros' disability and taught them ways to deal with his inappropriate behaviors, such as using redirection. His peers are important to him and he responds to their comments. Eros is learning English and has mastered his daily routine. He is playing very well with the other children in the classroom and the negative behaviors have significantly decreased.

Easter Seals, North Georgia is thrilled to be a Head Start grantee and is leveraging its expertise in early childhood disabilities services to benefit all children and families enrolled in our program.

Katy Beh Neas *is Assistant Vice President at Easter Seals Head Start Program. T: 202-347-3066, E: kneas@easter-sealsdc.org.*

BY ERIKA M. CARPENTER AND DOUGLAS W. NANGLE

THE COMPASS PROGRAM: ADDRESSING AGGRESSION IN THE CLASSROOM

AGGRESSION IN THE CLASSROOM IS A MAJOR CONCERN FOR HEAD START TEACHERS and is a primary problematic behavior reported by all preschool teachers. Up until about four years of age, physically aggressive behaviors, such as hitting and pushing may be evident. In the course of development, they usually give way to verbal aggression as children make gains in language, empathy, perspective taking, and the ability to delay gratification. But some children continue to exhibit high rates of physical aggression as they enter elementary school. They are at increased risk for a range of negative developmental outcomes, including peer rejection, serious conduct problems, delinquency, and eventual criminality (Coie & Dodge 1997; Loeber, 1997).

Photography by Penquis CAP

During "free play," children model the newly learned social skill with puppets

Head Start centers in the rural eastern Maine counties of Penobscot and Piscataquis are working to find the best ways to manage aggressive behavior in the classroom. For the past twenty years, the Psychological Services Center (PSC) at the University of Maine has held a contract with Penquis Community Action Program (Penquis CAP) Head Start to provide mental health consultation services.

The PSC is a training clinic affiliated with the doctoral training program in clinical psychology at the University of Maine. Penquis CAP, a private, nonprofit, community health and social service agency, coordinates the efforts of more than 26 local Head Start classrooms in eastern Maine.

The PSC provides biannual visits to each center to assess the overall center environment (e.g., safety, daily activities, facilitation of developmental skills, staff/children interaction). At the request of center staff, observations of specific children exhibiting difficulties (e.g., noncompliance, separation anxiety, aggression, etc.) are conducted. Treatment recommendations are provided, including staff-initiated procedures (e.g., teaching peer interaction skills to students, changing discipline strategies) and/or referral for further services.

Over the years, we have been frustrated and concerned by the steady stream of referrals involving aggression and poor peer interaction skills. Of the 177 children referred between fall 1991 and spring 1999, 40% exhibited difficulties involving aggression. Rather than address each case individually, we decided that a systemic form of intervention might be more beneficial.

Intervention in Curriculum

WE BEGAN DEVELOPING the Curriculum on the Management and Promotion of Appropriate Social Skills (COMPASS) program, a social-cognitive skills training curriculum. First, we piloted some of the COMPASS procedures by training a Head Start teacher to provide brief verbal instructions to the most aggressive children in one classroom. In a quiet, isolated location, the teacher engaged the child in conversation aimed at teaching three concepts based on the work of Zahavi and Asher (1978)—(1) aggression hurts other people and makes them unhappy; (2) aggression does not solve problems and only brings about the resentment of the other child; and (3) positive ways to solve conflicts are sharing, taking turns, and playing. The effects of this intervention were measured through behavioral observations and teacher ratings of behavior (completed by the assistant teacher who did not know which children received the training).

After treatment, the children were observed to display significantly higher levels of positive behavior (e.g., complying with teacher directives and playing appropriately with other children) and significantly lower levels of negative behavior (e.g., noncompliance and temper tantrums). Aggression decreased to levels comparable to that of their non-

aggressive peers. These changes in behavior were maintained at a 1-month follow-up observation period. Teacher ratings revealed that social behavior also improved and persisted one month later.

Program Components

ENCOURAGED BY THE SUCCESS of the pilot study, the 12-session COMPASS program was fully developed and is currently being evaluated in four classrooms. Researchers at the University of Maine worked closely with Head Start program staff to ensure that the curriculum was manageable and appropriate for use in their classrooms.

COMPASS consists of four major components—*instructions*, *modeling*, *rehearsal*, and *evaluation/feedback*. During "circle time," the children are *instructed* on one of eight individual social skills by puppets, who *model* the skill for the children. During "free play," all of the children rotate through a *rehearsal* station, where they re-enact the scene with the puppets and then practice the newly learned skill in a related activity planned by the teacher. A teacher is at the rehearsal station to provide feedback to the children and to ensure that the skill is rehearsed correctly. For example, for the skill "sharing," the puppets engage in a tug-of-war over a puzzle piece that is resolved by sharing. The puppets model how to share the puzzle pieces. At the rehearsal station, two to three children reenact the scene of the puppets sharing the puzzle pieces. The teacher provides cues to the children, if necessary. Finally, the children put a puzzle together with the teacher coaching and praising them in the art of sharing. We plan to revise the COMPASS program curriculum based on the results of our *evaluation and teacher feedback*.

It is our hope that COMPASS will function as intervention for those children who exhibit aggressive behavior and as prevention for others.

Next Steps

A PARENT COMPONENT is being developed to teach parents about the social skills being taught in the classroom and the best methods for reinforcing these skills in the home environment. The parent component is a critical addition to COMPASS because children are best served by consistency across the school and home environments.

It is our hope that COMPASS will function as an intervention and a prevention: intervention for those children exhibiting aggressive behavior and prevention for others. Research shows that half of all aggressive children in middle childhood were aggressive preschoolers, whereas the other half first displayed aggressive behavior in elementary school.

Moreover, the social skills taught by COMPASS will aid children who are behaviorally withdrawn or neglected by their peers. The COMPASS program was designed as a general social skills curriculum to teach all Head Start children how to navigate effectively their social worlds.

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THE EFFECTS OF VIOLENCE ON MENTAL HEALTH

Sometimes it seems that violence is accepted as just a fact of life in our communities. We see it reported on the daily news and glamorized in the media. Somehow we have learned to take it in stride. It seems the more violence that exists in our society, the higher our threshold for acceptance.

by TERRA BONDS

WORKING TOGETHER IN HEAD START, we have the power and the obligation to heal the violence in our community—if not for ourselves, then for our children. Witnessing violence and exposure to it can hurt all of us, especially our children, who are the most vulnerable.

Family Violence

FAMILY VIOLENCE OR ABUSE, whether physical, emotional, or verbal, is the most direct form of violence that children experience. It usually has the most profound and lasting effect on their development. Children who witness parental violence are seriously affected because of their proximity, the directness of the experience, and the importance of the primary caregiving context. Children who are victims may be scarred for life with irreparable damage to their healthy self-identity and capacity for establishing trusting relationships. Very young children are the most vulnerable targets of violence in the home. More abuse and more fatal abuse occur to children in the first year of life than in any other 1-year period in their development. The risk of family violence is increased substantially when other risk factors such as emotionally abusive relationships, substance abuse, or stressors associated with poverty, are present in their lives.

Community Violence

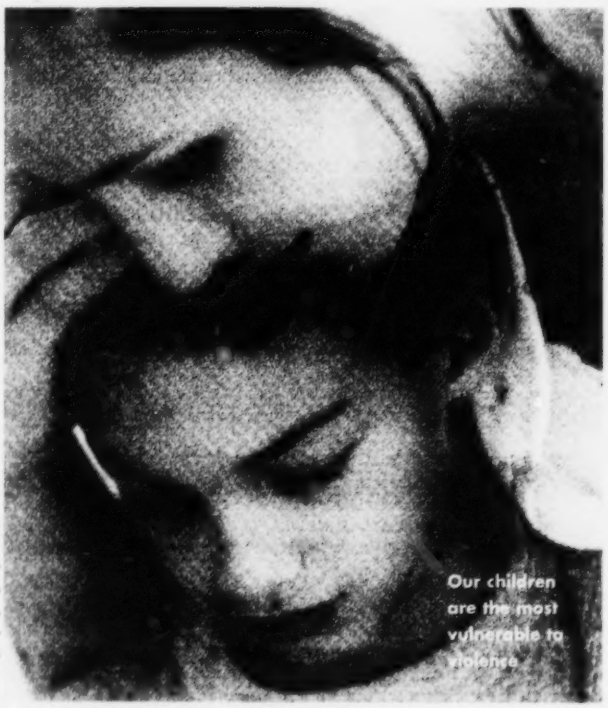
CHILDREN ARE OFTEN INDIRECTLY EXPOSED to violence in their communities. They may witness violent acts such as robberies, assaults, or shootings. Although infants are unable to process events outside of their immediate environment, they are tuned into the emotional responses of their caregivers. The very young child is primarily affected by the primary caretaker's response to the violence if it compromises the caregiver's ability to provide emotional consistency and protection to the child.

Older toddlers and preschoolers who have been witnesses to community violence are usually more aware of what has occurred and have a deeper understanding of what they have seen. They may show emotional distress as a result of witnessing the violence, as well as being affected by their caregiver's response.

Media Violence

MEDIA VIOLENCE IS ANOTHER FORM of indirect exposure. Some research has shown a relationship between children's aggressive behavior and viewing violent programming. Young viewers may experience desensitization or increased acceptance of violence as normal. They may evidence a "mean world syndrome," which is described as fearfulness that the everyday world is as dangerous as the television world (Murray 1997).

Although media violence has been found to affect children's behaviors, it is also important to take into account the amount of exposure to violent programming the child has had, the child's stage of development, and the way in which the media violence interacts with other family variables before determining the full impact on the child.



Our children are the most vulnerable to violence.

Photography by Eyewire

Behavioral Effects on the Child

CERTAIN BEHAVIORAL CHANGES (*see sidebar*) may be observed in children who have witnessed or been victims of violence (although some of the behaviors may also be in response to other "normal" developmental issues). If the child is exhibiting any of these behaviors in a sudden, intense, unrelenting fashion, gather as much information as possible about the child and his circumstances to determine the source of the behaviors and the best course of action. Your program's screening and ongoing assessments of children are important sources of information.

Head Start Policies

SUGGESTIONS FOR HEAD START PROGRAMS AND STAFF to develop policies and procedures related to violence include—

- Establishing procedures that will ensure the safety of children, parents, and staff who are faced with violent situations in the home, at the Head Start center, or out in the community (i.e., during home visits).
- Developing a referral policy that includes the services of a mental health consultant who helps the staff assess and identify services for the child and family.
- Exploring community resources that provide services for children and families who have been witnesses or victims of violence.
- Collaborating with agencies that provide services or training to families and staff related to violence awareness, prevention, and intervention.

Many Head Start programs around the country already have structures in place to address children's and families' needs for mental health services related to violence. In cooperation with local and national agencies, Head Start staff and parents can plan and use appropriate strategies to address the violence that interferes with our children's optimal development. General suggestions for addressing violence include therapeutic interventions provided by mental health agencies and communication strategies for caregivers (*see sidebar page 33*).

COMMON BEHAVIOR CHANGES

According to Honig (1993), children who have experienced violence may show its effects in any of the following ways—

- Crying frequently or constantly
- Wanting to be held constantly or stiffening when held
- Exhibiting aggressive behavior (i.e., hitting, biting, or kicking)
- Sleeping irregularities (i.e., trouble falling asleep or staying asleep, nightmares)
- Stuttering
- Showing changes in developmental functioning (i.e., toileting practices)
- Expressing fear or worry about being safe
- Withdrawing from social interaction
- Eating irregularities
- Exhibiting psychosomatic symptoms (i.e., headaches, stomachaches)
- Having lowered self-esteem
- Having difficulty in paying attention
- Being depressed

September 11th, 2001

WHILE WE DEAL WITH OUR OWN EMOTIONS about the tragedy of September 11th, we must be aware of the impression these events have had on the emotional development of the very youngest people in our country. Parents and educators, who are responsible for the health and well-being of children, must do everything possible to protect, reassure and restore a sense of security for our children.

Although young children's objective awareness of what has happened is very limited, they respond to the fear, pain, and tension of adults. Children will know if familiar adults are upset. Therefore, it is important that adults be aware of their own emotions and deal with them appropriately. Adults can discuss their feelings with children, but nevertheless, must model emotional strength and coping strategies. Caregivers

Continued on page 33

A HEAD START BULLETIN PULL-OUT

HELPING CHILDREN & ADULTS COPE WITH

Adapted from http://www.acf.dhhs.gov/sept11/public.htm

Pay attention to your own feelings and concerns. Take care of yourself.
Be aware that your moods and feelings will affect those around you.
Allow staff members time to talk and to express their feelings and concerns.
Provide guidance for families and staff members on how to help children deal with anxiety related to trauma and crisis. Call in consultants or experts if necessary.
Be aware that distress related to traumatic events may not show up immediately among adults or children.
Help families and staff sort out their feelings. Do not be judgmental. Keep in mind that there will be a wide range of reactions and experiences to any crisis.
Encourage parents to monitor their children's television viewing, especially the news and shows with violent content, including cartoons.
Reassure children that they and their families are safe. Provide extra comfort and contact frequently.
Maintain the typical, daily schedule of activities. This consistency will help children feel more secure and in control.
Be honest and open about traumatic events if the children are talking about them but carefully consider each child's developmental level when giving information.
Acknowledge the children's questions, even if you can only say, "I don't know the answer."
Do not tolerate prejudiced comments or behavior. Deal with them openly and immediately.
Create a climate of respect, tolerance, and acceptance of diversity in your setting.
Accentuate the positive. Point out the good around you (e.g., the rescue workers).
Pay attention to physical complaints, especially if they last more than one week or are severe. See a health care professional.
Monitor particularly vulnerable children.

Although some of these resources were developed in response to the events of September 11th, they also provide general advice about dealing with crisis and trauma in a community.

www.acf.dhhs.gov/sept11/public.htm
"Helping Children Handle Anxiety Related to September 11 Events"
"Coping with Disaster: Suggestions for Helping Children with Cognitive Disabilities" (Accessible in Spanish, Chinese, Vietnamese)
www.counseling.org/tragedy/tragedy.htm
"Helping Children Cope with Trauma"
www.naeyc.org/coping_with_disaster.htm
"Helping Children Cope with Disaster"
www.nasponline.org/NEAT/crisis_0911.html
"Coping with a National Tragedy"
www.ed.gov/inits/september11/index.html
"Helping Children Understand the Terrorist Attacks"
www.apa.org/psychnet/coverage.html
"Help with Trauma"
www.nimh.nih.gov/publicat/violence.cfm
"Helping Children and Adolescents Cope with Violence and Disasters"

HOJA DESPRENDIBLE DEL *BOLETIN DE HEAD START* DIRIGIDA A LOS PADRES Y EL PERSONAL

CÓMO AYUDAR A LOS NIÑOS Y A LOS ADULTOS A ENFRENTAR

Adaptado de http://www.acf.dhhs.gov/sept11/public.htm

Preste atención a sus propios sentimientos e inquietudes. Cuídese.
Esté consciente de que su estado de ánimo y sentimientos afectarán a aquellos que le rodean.
Permita que el personal tenga tiempo para hablar y expresar sus sentimientos e inquietudes.
Oriente al las familias y al personal sobre cómo ayudar a los niños a manejar la ansiedad que pueda derivarse de experiencias de trauma y crisis. Pida la colaboración de consultores o expertos si es necesario.
Esté consciente de que la angustia suscitada por estos acontecimientos traumatizantes puede no hacerse evidente de inmediato en los adultos o los niños.
Ayude a las familias a aclarar sus sentimientos. No juzgue sentenciosamente. Tenga presente que de cualauler crisis surgirán distintos tipos de reacciones y experiencias.
Incentive a los padres a que controlen lo que ven sus hijos en televisión, particularmente las noticias y los programas de contenido violento, incluso los dibujos animados.
Tranquilice a los niños, explicándoles que ellos y sus familias están a salvo. Bríndeles con mayor frecuencia el consuelo y el contacto que necesitan.
Mantenga el típico horario diario de actividades. Esta constancia ayudará a que los niños se sientan mas seguros y en control.
Sea honesto y abierto acerca del desastre ocurrido y los sucesos actuales si ve que los niños conversan al respecto, pero tome cuidadosamente en consideración el nivel de desarrollo de cada niño cuando comparta información.
Responda a las preguntas de los niños, aún cuando sólo pueda decir: "no sé la respuesta."
No tolere conductas o comentarios prejuiciosos. Aborde el tema de inmediato y abiertamente.
Cree un clima de respeto, tolerancia, y aceptación de la diversidad en su ambiente.
Recalque lo positivo. Haga notar lo bueno que hay a su alrededor (por ejemplo, los trabajadores de rescate).
Preste atención a las dolencias físicas, en especial si duran mas de una semana o son severas. Vea a un profesional de la salud.
Vigile a los ninos que son particularmente vulnerables.

Aunque algunos de estos recursos se desarrollaron como respuesta a los sucesos del 11 de septiembre, también proporcionan consejos generales sobre como manejar las crisis y los sucesos traumatizantes en la comunidad

www.acf.dhhs.gov/sept11/public.htm
www.counseling.org/tragedy/tragedy.htm
www.naeyc.org/coping_with_disaster.htm
www.nasponline.org/NEAT/crisis_0911.html
www.ed.gov/inits/september11/index.html
www.apa.org/psychnet/coverage.html
www.nimh.nih.gov/publicat/violence.cfm

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Continued from page 30, The Effects of Violence on Mental Health

must be careful to maintain close, loving, nurturing interactions with the child. They must also take care of their own mental wellness.

The recommendations on the pull-out (*see page 31*) can assist parents and caregivers with children (and other adults too) who were not directly affected by the World Trade Center or Pentagon bombings. Children who have lost loved ones in either of these tragic events may need to receive more intensive mental health assessment and services.

Childhood is associated with innocence, hope, and promise for the future. Children have the ability to stimulate protective urges in adults who are motivated to shelter them from the danger and damage that violence triggers. Let us all work together to help protect our children by providing them with the emotional support and positive experiences they need to thrive.

Photography by Eyewire

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SOLUTIONS FOR ADDRESSING VIOLENCE

The mental health services will assist children in coping with violence in their community or in their homes. Suggestions to help children include—

- In a safe environment, children who have been witnesses or victims can process their emotions and the events. Not all children develop overt symptoms associated with trauma. The specific kind of intervention needed depends on the form, level, and duration of exposure that the child has had. Interventions should begin as closely as possible to the traumatic event to decrease the long-term impact of the trauma.
- This support should come from non-offending family members, caretakers, and teachers.
- They need to talk about what happened and have their experience validated by a parent (non-offending adult), teacher, or mental health consultant. Younger children may express themselves primarily in their play or drawings.
- The media can be a powerful tool for education, but only if it is used with close adult supervision. What children see becomes part of their inner world. Spend time talking or reading to the child.
- Whenever possible, eliminate physical confrontations or arguing in the presence of the child.
- For example, console when the child is upset, or give a hug for reassurance.

REFLECTIVE SUPERVISION

Utilizing reflective supervision in your Head Start program and setting a good foundation for best practices. by Jaclin Pfliegar

Mary loses confidence in her ability to be successful in her new role. What more can she do?

Mary, a new Head Start teacher, is having difficulty with Sarah again. Every time the class sits down for a family style meal, Sarah refuses to behave. If Mary can even get Sarah to sit in a chair, she begins to throw food and kick other children under the table. She typically becomes violent when Mary tries to quiet her. Sarah's behavioral difficulties are consuming the majority of Mary's time and energy, and increasingly Mary has less of herself to devote to the other kids in the classroom. Lately, Sarah's behavior has become even more unmanageable, and other children in the class are beginning to act out as well.

Mary knows she cannot handle this problem alone. She has met with Sarah's mother, Susan, who shrugs off the behavior. Susan claims there is nothing she can do, she has other children to worry about, and she cannot enforce the behavioral management plans at home that Mary has tried to put in place in the classroom.

Mary is hesitant to tell her supervisor, Carlos, that she is having problems with her new job, but she decides to speak to him. When she approaches Carlos, he tells her he is too busy with more urgent problems. Mary begins to feel helpless and alone. Eventually, the children begin to control things and

THIS SCENARIO IS FAMILIAR to anyone working with young children. Mary is presented with a problem that becomes unmanageable. She has tried everything she knows to solve it and has even asked for help, but no one seems willing to work with her. Mary may begin to feel like a failure at her job when actually, everyone involved has failed.

How could this situation have been handled differently? How can supervisors ensure that their coworkers and peers do not feel alone? The answer may lie in creating a workplace environment where reflective supervision is integrated into the overall framework of the agency.

Learning—in the Context of Relationships

THE MOST POWERFUL ENVIRONMENT for learning takes place in the context of relationships—people learn and are most apt to be influenced when interacting with other people. Leaders in the field, including J. Bertacchi and T. Norman-Murch (1999), emphasize that reflective supervision promotes learning in the context of the relationships and interactions in which it occurs. It takes into account the process of learning as well as the content that is learned. The collaborative process between supervisor and teacher becomes as important as what was actually discussed since the communication and problem-solving techniques used in the dialogue are part of what is learned. Often, when we see certain behaviors modeled in relationships, we tend to mimic these behaviors in later situations—at times intentionally, such as when the behavior seemed particularly effective, and at times subconsciously, such as when we have only been exposed to one way of handling a situation.

Reflective supervision entails the supervisor taking on the roles of teacher and coach. The learner in the example above would be Mary. If reflective supervision had been the guiding principle, in addition to talking about the issue at hand—in this case, behavior management—the supervisor would have modeled behaviors that the teacher, Mary, could then use in

5 CHARACTERISTICS THAT DEFINE RELATIONSHIP-BASED WORK

The following concepts should appear in daily routines to reinforce positive child development (adapted from Bertacchi 1996):

- ✓ Safety and Trust
- ✓ Mutuality of Shared Goals
- ✓ Commitment to Evolving Growth and Change
- ✓ Commitment to Reflecting on the Work
- ✓ Respect for and Getting to Know Staff
- ✓ Sensitivity to Context of the Work Environment
- ✓ Open Communication
- ✓ Standards and Goals for Staff to Strive Toward

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the classroom when working with the children or with colleagues or parents. By working collaboratively to reflect on the situation at hand, Mary's supervisor would have been able to teach her best practices.

A Collaborative Dialogue

Reflective supervision is essentially a collaborative process that requires open-ended communication, and is most effective within a trusting relationship. Supervisors should encourage staff to express themselves and freely share their perspective on challenges and possible solutions. Clear and comfortable communication will make it easier for the supervisor to accurately assess problems and the level of assistance needed by the teacher. By engaging the teacher in a two-way conversation about the problem, and genuinely listening to her perspective and ideas, the supervisor is also modeling effective techniques for solving frustrating dilemmas. In effect, the supervisor takes on the role of coach as he supports the teacher in her professional growth and in the resolution of her specific problem.

Building on Strengths

Reflective supervision is also a strengths-based approach. The supervisor should concentrate on the teacher's positive qualities and work in collaboration with the teacher to solve the problem. The focus on Mary's strengths and appropriate actions taken will allow both Mary and her supervisor Carlos to assess accurately the problem and find the best solution. This focus also reinforces Mary's positive steps and so increases her confidence in her ability to handle her job.

By using many of the characteristics that model effective relationship-based work (*see side bar*), Carlos could have set the tone for a meaningful and instructive interaction. In essence, his reaction of not sitting down and listening to Mary was modeling only one thing—that her problems were not important. Allowing Mary to express her concerns in an open-ended conversation may have let her effectively talk out the problem. By reflecting on the situation and working through the problem together, Carlos would have also shown a willingness to invest his time and expertise in the development of his staff—the front-line people whose skills determine the quality of the services provided by the Head Start program.

By ignoring Mary's request for help, Carlos lost an important opportunity to create a "teachable moment" in which he could model behaviors that Mary could then follow when working with children and families. In listening to her frustrations and concerns, he would have objectively been able to assess the situation, and then ask Mary for the type of feedback that would be most beneficial to her. For example, he could have offered to send Mary to in-depth training on behavioral difficulties in young children. He could also have offered to bring in an outside consultant to assess Sarah's behavior and help Mary develop a more effective behavior management plan. He may have been able to ask targeted questions that would have helped Mary come up with the solution on her own, allowing Mary to build her confidence and giving her a useful technique that she could then use in speaking with Susan's mother. Or maybe listening to Mary was all that Carlos needed to do in this case. Reflective supervision would have allowed the best solution to surface.

> The supervisor should concentrate on the positive qualities and work with the teacher to maximize those strengths.

The Carryover Effect—Parallel Processes

The relationships we model in the workplace carry over into the interactions we have with families. In the case of Mary and her supervisor, Carlos, his lack of interest in Mary's difficulties with Sarah might have carried over into the way that Mary handled Sarah in the classroom. Mary may have written off Sarah's

Both supervisors and teachers have the critical role and responsibility of modeling best practices for their programs.

behavioral difficulties as unimportant—as Carlos did when Mary approached him—and allowed the behavior to continue. Susan, Sarah's mother, may have come to Mary down the road with problems she was having at home with her daughter. Mary may have acted similarly to the way Carlos had treated her, such as telling Susan that she could not help her because she has too many things to handle just in her classroom.

Mary would probably not have been aware of the connection between her interaction with Susan and her earlier interaction with her supervisor, yet that earlier interaction set the tone and modeled the way—even if inappropriately—to handle a difficult situation. Improving inter-staff relations and processes is crucial to the outcome of the services we provide, since the relationships within the agency often parallel those that staff members experience with families.

Overcoming Barriers to Reflective Supervision

TO CREATE A "WIN-WIN" SITUATION for all people involved, all levels of the organization must work together to create an environment for shared learning. Obstacles may be encountered when first trying to implement reflective supervision. For example, it is sometimes difficult for staff to get past the traditional views of and attributes associated with supervisors, such as being authoritarian figures who are only there to judge teachers' competency. A teacher may feel that her supervisor does not understand her problems and is too far "removed" from the classroom. Over time, the two-way conversations and sense of collaborative decision-making that are a central part of reflective supervision help create an environment where teachers do not feel isolated and supervisors are no longer "removed" from the daily interactions and challenges of the classroom. With time and practice, these supervisor stereotypes can be broken down, and ideally, the teacher will feel at ease discussing her problems.

In developing an environment for shared learning, it is important to stress common beliefs, such as Head Start's family-centered approach to services where the family's well being is put at the center of all problems and concerns. Although the supervisor and teacher have different job roles, and at times different perspectives, both are working toward a common goal—improving the lives of children and families. The commitment that staff members feel toward their jobs can be a persuasive reason to put differences or discomfort aside. This is important motivation for encouraging teachers to overcome obstacles in the classroom.

The way we interact with each other within our Head Start programs can have serious implications for our work with children and families. All members of the agency have an important responsibility to children and their families that begins with the recognition of the power of a seemingly simple interaction. Supervisors and teachers have critical roles. They are both responsible for modeling best practices—for their colleagues, the parents, and ultimately, the children.

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BY BEVERLY GOULD

EARLY CHILDHOOD BEHAVIORAL SPECIALIST

AN INTERVIEW

An interview with Paula Tripp, Anita Hoag, and Jeannie Liwanag
EOC Head Start of San Luis Obispo, California

Question: Why did your program choose to develop the Early Childhood Behavioral Specialist position?

Answer: Teachers in our Head Start classrooms have been encountering children's behaviors that are becoming more difficult and at times even violent. We have children with severe temper tantrums, children with rage, and children that bite others. Early childhood educators have not been receiving the training and resources they need to address these behaviors.

Head Start values each child as an individual and the development of self-esteem in the early years is what Head Start philosophy is about. Promoting the mental health of a child is a challenge for any teacher, however skilled, and we needed to support the staff members who deal with these children and families.

Question: What do you see as the reasons for the increase in unmanageable behaviors?

Answer: Children experience violence in the media, on the street, and at home. Some children deal with this as well as parental substance abuse, incarceration of a parent, and other situations. Children exposed to these situations are more likely to display violence and atypical behavior.

Question: Can you describe how you developed this model?

Answer: Our program addressed the increase in children's behavioral concerns in a unique way. We studied the referrals made to the disabilities and mental health areas of the program for the past two years. Sixty percent of all referrals were behavior related. We employed a Licensed Clinical Social Worker (LCSW) and a Mental Health Assistant to support children, families, and staff, but this model only addressed about ten percent of the referrals because of the intensity of the intervention needed by the children. The timelines from referral to intervention were also a problem. Sometimes the parents were not brought into the center to discuss their children's difficulties. In addition, the mental health staff (LCSW and assistant) had no formal early childhood education and therefore, were only performing triage and giving community referrals. This model did not seem to be meeting the needs of the classroom staff. The staff informed us, through surveys and interviews with a consultant, that they needed someone who would respond rapidly, directly model how to intervene, help them develop behavior plans, and locate resources. They also wanted someone with experience in a preschool setting.

Question: How were you able to fund these positions in your Head Start programs?

Answer: The changes took place when the new performance standards were introduced. We decided that we needed to reorganize the program and change some of the management positions to accommodate the mental health needs. We developed a position entitled Early Childhood Behavioral Specialist (ECBS). The ECBS was not trained in mental health, but had a very strong early childhood education background. A Mental Health Consultant was brought in to do intensive training. The ECBS (there were two hired for a program of 387 children) also attended training on the "Second Step" conflict resolution/anti-violence curriculum, as well as other training on children's behavioral issues.

Question: What exactly does the Early Childhood Behavioral Specialist do?

Answer: In the ECBS model, they are the first to respond to referrals. They are reachable during working hours or after hours for behavioral emergencies. They perform triage over the phone and personally go to the classroom or send another person.

Specialists meet with staff and families to develop behavior plans. They refer families and children to mental health professionals in the community who are

Photography by EHS NRC

able to work with them while they are in our program and after they move on. The specialists also maintain a database to provide handouts to parents and staff about specific behavior concerns.

Question: Why did you choose to hire teachers to fill the ECBS role?

Answer: We needed someone with a strong early childhood background. Teachers know child development so well that they can distinguish between age-appropriate behavior and behaviors that should cause concern. Teachers can identify with the frustrations of other teachers and there is an easy rapport. Teachers are able to model appropriate guidance in the classroom, review environments, and support the teachers' group management skills. They can identify needs and plan training for the staff in behavioral issues. They can go into a classroom for consecutive days to help bring the classroom under control.

Question: What specialized training does the Behavioral Specialist have?

Answer: Our ECBSs have many years experience as classroom teachers and a knowledge base in both mental health and education. They have learned about theories and interventions through extensive workshops and ongoing collaboration with our mental health personnel, who are available for regular consultation. It is important for them to have a grounding in the behavioral sciences and comfort with the social, emotional, cognitive, academic, language, sensory, motor, and physical domains. For example, it is helpful to know about brain development and how certain brain-related difficulties affect a child's behavior and learning potential. This allows the teacher to plan strategies that aim for that child's strengths.

Question: Can you describe a case to to illustrate how the ECBS would operate?

Answer: One child recently came to our center with no background information and fairly soon, began to curse, hit, and bite. We observed that he had poor social skills, was easily over stimulated, had poor impulse control, and became aggressive when his demands were not met. We learned that his mother had had substance abuse problems throughout her pregnancy and was currently incarcerated. First, this boy was referred for play therapy and seen on-site twice a week. The therapist, teacher, and his grandparents developed a plan of action for him. An instructional aide was assigned to shadow him to support his developing self-control and determined that the interventions were working.

Question: What have been some of the other positive effects of this model?

Answer: This model just ended its third year and the number of referrals drastically decreased. Specialists provide instant help and intervene before negative behavior escalates. The instructional aides in the classroom also provide support. They do not function as playmates, but are close by to help when necessary, which frees the teacher to interact with all of the children and helps them avoid feeling burned out. The classroom staff members feel that specialists have been the greatest addition to the program in years.

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BY BRENDA JONES HARDEN

HOME-BASED EARLY HEAD START
"KITCHEN THERAPY"

LANITA'S COMMITMENT TO HER TWO DAUGHTERS IS READILY APPARENT TO JANICE, an Early Head Start (EHS) home visitor, but Janice has also noted several issues. The older daughter has the expressive language skills of a much younger child. She tends to be very oppositional and ignores her mother's directives or attempts to engage her. Lanita's younger daughter has a very sad manner, is hesitant to join in play with her sister, does not reach for her mother when she hurts herself in play, and cries inconsolably whenever Janice attempts to leave. Lanita is also extremely sad, lethargic, and unable to focus on even small tasks. Lanita's boyfriend supports her and her children, but she does not seem interested in maintaining this relationship. She does not find joy in anything she does nor does she have anticipation for the future. In her discussions with Lanita, Janice has learned that Lanita's grandmother, who raised her, died two years ago and that Lanita has an older child who was placed in foster care at birth.

When families such as Lanita's are referred to Early Head Start programs, the programs are often at a loss as to how to address their psychological needs. Although Early Head Start is not a mental health program, it has an established goal of promoting the development of the whole child, including the child's emotional development. For infants and toddlers, the major strategy for addressing their emotional needs is enhancing the parent/child relationship. In fact, the development of the young child across domains is exceedingly difficult to achieve without the support and well-being of the parent, even if the child participates in the highest quality intervention.

Photography by EHS National Resource Center

Two-year-old Montez Brown with his mother and Home Visitor

Infant mental health services are designed to enhance the emotional well-being of young ch n through their relationships with their caregivers. Selma Fraiberg (1980), a pioneer in the infant mental health field, referred to these services as "kitchen therapy," an allusion to the home setting in which she felt these services were best provided.

Providing infant mental health services in the context of the home has several advantages—

- Intervention that is conducted on the family's turf allows for increased comfort, openness, and trust on the part of the family.
- Observation of parent/child behavior is possible in familiar surroundings and where the larger family system is present (e.g., grandmothers).
- Services can be more flexible in terms of time, space, and focus of work.
- Intervention can incorporate the family's resources and address the family's needs in a concrete manner.
- Intervention can capitalize on natural parent/child interactions in the home, such as feeding, bathing, grooming, and putting the child to bed.

Home Visitors' Role

Alicia Leiberman (1999), an expert in the field of infant mental health, has stated that you do not have to be a therapist to be therapeutic. In other words, there are specific services that can be delivered by EHS staff with appropriate training. Staff members should be consistently supervised. They should discuss families and what needs to be accomplished in the home visits. They should have access to regular mental health consultation to learn more about particular mental health issues and specific strategies to employ with families. Finally, if possible, programs should develop collaborations with local mental health services where parents can obtain treatments for any mental health difficulties.

With an overarching goal of enhancing the parent/child relationship, infant mental health services should focus on meeting the psychological needs of the parent, supporting the parent to attend

to the child's cues, enhancing parent/child interaction, and fostering the child's sense of security within the parenting relationship. The following are strategies to meet these objectives in the context of EHS home-visiting programs.

Psychological Needs of the Parent

Jeree Pawl (1998), who has spoken and written on the provision of infant mental health services, coined a "platinum" rule: *Do unto others as you would have others do unto others*, meaning home visitors should nurture parents in the manner that parents should nurture children. Parents should have the opportunity for an emotionally corrective experience with the home visitor, in which they receive unconditional acceptance throughout the duration of their relationship with the program. Home visitors must provide consistent and empathic care to families, even when parents display "resistance"—such as not being home for appointed visits or expressing anger at the home visitor. In addition, home visitors can do initial screenings regarding the psychological health of the parent. Many programs screen parents for depression using a questionnaire. Parents who report clinical symptoms can be referred for individual psychotherapeutic intervention.

Attending to the Child's Cues

Pre-verbal children have to rely on the insight of their caregivers regarding their needs. They need adults who understand the message behind their cries, facial expressions, and body movements. Home visitors can help parents pick up these cues by talking about the child's need for the parents, pointing out specific child behaviors and potential reasons for the behaviors, and mimicking the child's voice and asking for certain parental responses. Parents can be coached to understand their infants' temperaments and preferences, and to anticipate their moods and needs. Emphasis should be placed on parental responsiveness during times of distress. For example, when an infant is most vulnerable (e.g. hungry, tired, frustrated, fearful), parents can be coached to remember the behaviors their infants display and the strategies that are effective in consoling them. Coaching the parent during the home visit to use the consoling strategies at the time these behaviors are displayed can be beneficial.

Fostering Parent/Child Interaction

Building a relationship is best carried out in the context of "in-vivo" parent/child interaction. Home visitors can engage parents and infants in play interactions to provide them with positive joint experiences without pressure. They can use the toys and materials that are in the home to increase the likelihood that mothers will repeat these activities when the home visitor is not there. Similarly, capitalizing on the routine interactions between the mother and her baby (e.g., grooming, feeding, putting to bed) allows the caregiver to work on relationship issues with the infant during frequent or daily activities. Finally, coaching the parent to use playful, fun types of interaction can enhance the parent/child relationship.

Enhancing Child's Sense of Security

Developing an attachment to a primary caregiver is the major social-emotional milestone of the infancy period. Scholars have emphasized that security of attachment during the infancy period leads to later positive outcomes across all domains of child development. Thus, when home visitors work toward establishing secure attachments between parents and children during infancy, they are potentially supporting the child's long-term development. Home visitors can accomplish this in several ways, including 1) promoting parents' constant expression of love and care for their infant; 2) coaching parents to be consistent, gentle, and developmentally appropriate in their provision of structure and discipline; 3) encouraging parents to be a secure base for their infants when they are distressed; 4) helping parents think through how to handle separations from their infants appropriately; 5) facilitating parents' feeling of joy when they are with their infants; and 6) meeting the child's needs as responsively as possible.

Other Services

Deborah Weatherston (1995), who directs one of the few long-standing

infant mental health training programs in the country, has delineated a set of comprehensive infant mental health services that should be provided to families at environmental risk. In addition to the relationship-focused therapeutic intervention that should occur at each home visit, she suggests including the following intervention modalities—

- *Developmental Guidance*
  Educating the parent about developmental milestones and appropriate expectations for their children is a major component of the services that Early Head Start programs provide. This guidance should be provided in the course of the moment-to-moment interactions that the parents have with their children. It is less effective to lecture to the parent.
- *Emotional Support for the Parent*
  Because the role of Early Head Start home visitors is not to provide mental health services to parents, it is essential that programs have a mental health consultant on staff who can offer such services or have a cooperative agreement with a local mental health provider. In rural areas, where it may be difficult to access a mental health provider, it may be appropriate to arrange mental health supervision by telephone or Internet for the most qualified person on staff to provide such services. As discussed in the previous section, home visitors themselves can augment this type of mental health intervention by directly providing emotional support to the parent as well.
- *Concrete Services for the Family*
  Families at environmental risk are beset by many stressors that come from not having adequate resources, such as food, housing, money, and transportation. For parents to focus on psychological issues, they must have their basic needs for survival met. Home visitors must address these issues with parents through joint problem solving as well as direct referrals. This work can be linked to the goals of infant mental health intervention by promoting parental self-esteem when parents overcome one of these barriers, and addressing how the parents' stress affects the child's psychological well-being.

Guidance should be provided through the moment to moment interactions between parents and children.

In sum, infant mental health intervention can facilitate the accomplishment of the overarching goal of Early Head Start—to promote optimal child development. Many scholars and clinicians advocate for the provision of preventive infant mental health services in the context of the home. Early Head Start home visitors have a unique opportunity to support child and family development through this modality. By receiving infant mental health services in the home, families like Lanita and her children can move toward the sense of psychological well-being that is essential for their capacity to progress toward other developmental goals.

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BY CECELIA GODFREY

WORKING WITH NATIVE AMERICAN FATHERS

MANY OF THE PROGRAMS IN THE AMERICAN INDIAN/ALASKA NATIVE PROGRAM Branch are implementing mental health services for children and families. The services range from mental health professionals on staff to partnerships with local health departments and mental health agencies. The Red Cliff Band of Lake Superior Chippewa Early Head Start is attempting to meet the mental health needs of families through a new Fatherhood Project.

The Red Cliff Band of Lake Superior Chippewa live on the Red Cliff Reservation in northwest Wisconsin on the shores of Lake Superior. Young families must overcome problems with unemployment, financial difficulties, alcohol and substance abuse, lack of education and job skills training. Unemployment on the reservation is 40%, and 33% of those families who work are employed in jobs that pay well below the Federal poverty level. Twenty-six percent of births at Red Cliff are to teenage mothers. Young fathers are often not present in the home and are not actively involved in rearing their children. They also struggle with cultural heritage and role model issues.

Although it is a small reservation, the tribe has a Head Start program, an Early Head Start program, a health clinic, a youth services program, and a community center. These programs serve 95 children and their families on the Red Cliff Reservation. The Red Cliff Early Childhood Center (ECC) serves all 75 children through Early Head Start, Head Start, or Child Care. All age-eligible children on the reservation and all tribal families within ten miles of the reservation may apply to one of the programs at the Early Childhood Center. The Center provides comprehensive services to pregnant women and children birth to five through strong collaborations and community partnerships.

Through Head Start and Early Head Start, families recognize the need to involve fathers more meaningfully in the lives of their children.

Traditionally, the mother and her family are responsible for child rearing among the Red Cliff Chippewas. Through programs like Head Start and Early Head Start however, families recognize the need to involve fathers more meaningfully in the lives of their children. Unfortunately, there are few role models because fathers have not been involved in child rearing for many generations.

Young fathers, who are often struggling with issues of survival, have not had an easy transition to active involvement in raising their children. They often feel guilty for not being involved in their children's lives, but have little access to opportunities to improve involvement. Given this history, the Red Cliff Early Head Start applied for funds for a Fatherhood Initiative to help meet the needs of the fathers on the reservation.

Dee Gokee-Rindal, the Red Cliff Early Childhood Center Director, has worked for several years to develop mental health services to meet the needs of the families at Red Cliff. The goals for serving families at Red Cliff Early Childhood Center include increasing social competence of children; enhancing a child's social, emotional, cognitive, and physical development; supporting parents as primary nurturers of their children; and providing continuity of care for children and families. The program has established partnerships with the Red Cliff Community Health Center and the Bayfield County Birth to Three Program to provide support services to families. In addition, the program has been working with a mental health consultant for the last two years.

Dawn Nixon is completing her work in a doctoral program and provides services as the Early Head Start/Head Start mental health professional to families 10-15 hours per week. She provides therapeutic intervention on-site for children and meets with families on-site or in their home, depending

on their preference. Dawn has worked with the program to try to identify additional support for families.

Red Cliff was recently awarded a Fatherhood Demonstration Grant. The grant will utilize the Touchpoints program developed by Dr. T. Berry Brazelton (1992) to strengthen the parenting of young parents, with a focus on young fathers. The goal of this grant is to work with young fathers to increase their involvement in the lives of their young children. Although both Dee and Dawn are working on this project, they are currently in the process of hiring a father to coordinate the grant. Specific components of the grant will consist of—

- Prenatal education that will include fathers;
- Newborn assessment;
- Home health care visits;
- Postnatal support groups for mothers and fathers;
- Home health visits through Indian Health Services.

The Red Cliff vision of Touchpoints includes a community-wide approach. Staff from the Health Center and other community agencies will be trained along with the Early Childhood Center staff. Five staff members and community services providers attended training at the Brazelton Institute in January 2001 and returned to the program to train other staff. The goal of the program is to create a new tradition where men become equal partners in raising their children—blending Chippewa traditions with the Touchpoints program.

The goal of the program is to create a tradition where men become equal partners in raising children—blending Chippewa traditions with the Touchpoints program.

Touchpoints will be a program-wide initiative, working with families in both center-based and home-based settings. The work of the Touchpoints trainers will increase staff and family knowledge of child development, help young parents understand the behaviors and cues of babies from their first day home through their infancy, and work with pregnant mothers and their partners to build a working relationship that will carry them through the Head Start years.

The goal of the Red Cliff Early Childhood Center is to work with families in a respectful manner at all times, understanding culture and heritage and integrating the values of the culture into their work with families. The fatherhood grant is one of many initiatives the program will utilize to support families in their community. ■

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online... For more information on Head Start, visit our site at <www2 acf dhhs.gov/programs/hsb/>.

BY DONALD WYATT AND JENNIFER BOSS

MENTAL HEALTH IN THE MIGRANT HEAD START COMMUNITY

WHEN WE THINK OF MENTAL HEALTH WE MIGHT ENVISION SOMEONE lying on a couch undergoing intense psychological therapy to uncover the evil demons that lie within. Thankfully, a more useful understanding of mental health is developing. This process is most evident in Head Start programs serving migrant and seasonal farm workers.

To discuss the mental health needs of migrant farm worker families, you must understand them in context. Migrant farm workers travel thousands of miles to plant, harvest, and weed crops. Parents work long hours in the fields and are often forced to leave young children in child care or in the care of older siblings for eight to twelve hours a day. The pay is poor and in spite of the critical service these skilled laborers bring to communities, migrant farm workers are not always accepted, or, in some communities, even tolerated. They and their children are subjected to racism and classism typical for people that come to an area for a limited time. Sometimes migrant families have to sleep in their cars because no housing is available. When available, it is often substandard. In some instances, banks will not cash their paychecks, and grocery stores have been known not to sell to them. Yet many times each year, migrant farm workers pack up their families to begin the journey over again.

Despite the grueling lifestyle, migrant farm worker families have incredible strengths. They are very family-oriented. The majority of migrant families are two-parent families with close, supportive, extended family members. This dependence on and belief in the strength of family extends to the larger "community family." Many migrant communities have informal support networks which help protect families from the stress associated with their lifestyle.

Photography by Industrious MHS

Migrant parents hope to provide better lives for their children

Migrant children and families are resilient. In the face of numerous transitions between places and caretakers, most migrant children develop healthy and appropriate attachments to their caregivers. Also, despite their marginalization in the community, parents still seek out services offered by Migrant Head Start programs. Most importantly, migrant parents hope to provide better lives for their children. Hope and resiliency sustain migrant families as they leave their homes to return to areas far away to harvest crops. The trusting relationships that many migrant families have with the Migrant Head Start programs nationwide have added to the network that supports families' and children's mental health.

To gain a better understanding of how Migrant Head Start programs respond to the mental health needs of migrant farm workers and their families, we interviewed several programs that provide exemplary mental health services. The programs discussed their challenges and successes serving migrant families and described a complex system of mental health services based on promotion, prevention, and intervention.

Addressing mental health issues in migrant families is complicated by cultural differences, lack of trust, and language barriers. Migrant families are typically not forthcoming with their problems. Often families believe that health concerns should be dealt with within the family, not through formal health care systems. Many families also have strong religious and cultural beliefs that affect their response to mental health concerns. There is a belief among some people of Latin descent that physical and mental health issues arise in children as a punishment for past sins of the parents. Many parents choose to use home remedies and spiritual healing techniques when addressing physical or mental health concerns.

Trust issues arise from a long history of conflict with government agencies regarding immigration and naturalization, even though most migrant farm workers have legal status in this country. Some migrant parents choose not to use formal systems of care because of fear of government action against them, such as being deported or losing benefits.

The vast majority of migrant farm workers speak Spanish. Of the many

agencies that provide mental health services to families, most are not equipped to handle the needs of migrant families. Often, there are no Spanish-speaking mental health professionals or no one familiar with migrant families' culture or needs, especially if intensive intervention is required.

The Migrant Head Start program is in the unique position to become a "hub" of services because of its level of trust and sensitivity to culture and language. Families often take advantage of community services because of the link that Migrant Head Start programs provide.

Most Migrant Head Start programs approach mental health needs through promotion, prevention, and intervention. They support mental health promotion by training staff and parents and working with community partners. One program instituted the concept of "wellness" by developing a wellness committee consisting of parents and staff who advise the program on mental health and wellness issues. Some programs include mental health professionals on the Health Services Advisory Committee to serve as links to the community for mental health issues. Most migrant programs address the unique needs of the migrant families by ensuring that information is shared and trainings are conducted in the language of the families, and that the cultural needs of the families are incorporated into all services.

Migrant Head Start programs address prevention of mental health complications in strategic and creative ways. Staff are trained to observe children and administer developmental screenings in the children's home language, as required by the Head Start Program Performance Standards. Many programs maintain primary caregivers who are responsible for a small group of children. Some programs attempt to provide continuity of care, where a caregiver stays with the same group of children until the age of three. Despite complications related to shortened programs and family mobility, these efforts are made because of the importance of supporting the social-emotional needs of infants and toddlers by creating a trusting and secure environment.

Several programs stress the importance of including all staff in trainings, even bus drivers who are often the first point of contact for parents and children. Parent support groups provide opportunities to share their struggles, questions, and successes. Many Migrant programs hire former Head Start or migrant parents to ensure a bilingual, bicultural staff.

As designated by the Program Performance Standards, Migrant Head Start programs must have access to a mental health professional to observe the children for the purpose of intervention and to make recommendations for further testing or treatment. This person often provides the training for staff and parents, as well as services for the whole family. A number of programs describe the challenges to hiring bilingual, bicultural mental health specialists, especially in rural areas of the country. All of the programs interviewed stressed the critical importance of being able to communicate with families and understand the culture.

Addressing the emotional needs of migrant farm workers is challenging. One of the answers to the challenge lies in the spirit of Migrant Head Start and the desire of each program to optimize service delivery to children and families. Each agency faces similar challenges when working with the mental health needs of migrant families. Programs cannot face these challenges alone and must continue to be creative and pull in community partners, such as community clinics, churches, and other local agencies, whenever possible.

Migrant Head Start programs hold the honorable position of trusted partner to many migrant families. Respect for culture, language, community collaboration, cooperation, and the continual reassessment and improvement of the service approach hold the greatest promise for addressing the mental health needs of migrant farm worker families. ■

We would like to thank the Migrant Head Start grantees that gave their time to speak with us for this article. The information they provided was both valuable and informative.

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BY DEBORAH RODERICK STARK, RACHEL CHAZAN-COHEN, AND JUDITH JERALD

THE INFANT MENTAL HEALTH FORUM

SUPPORTING THE SOCIAL AND EMOTIONAL WELL-BEING OF CHILDREN IS A goal shared by staff of both the preschool Head Start and the Early Head Start programs. In recent years, the country has paid increased attention to the mental health of children. However, most discussions have focused on the schoolage population and issues surrounding treatment rather than the full continuum needed to support children of all ages—beginning with promotion and prevention and including intervention. Teachers and parents in the Head Start community—and in early care and education settings—report that they struggle to understand and address the mental health needs of very young children and their families, and that they lack the knowledge, skills, and resources within the community to assess and serve children.

Photography by Eyewire

Head Start is a leader in infant mental health

Hearing these concerns, the Department of Health and Human Services—under the leadership of the Head Start Bureau and the Commissioner's Office of Research and Evaluation (CORE), both of the Administration of Children, Youth and Families—held an Infant Mental Health Forum on October 23-24, 2000. The Forum was attended by more than 140 people representing parents; Early Head Start and Migrant Head Start directors, program staff, and home visitors; early educators; training and technical assistance providers; researchers; pediatricians; psychiatrists; psychologists; social workers; Federal partners; and private foundation representatives. The purposes of the Forum were to (1) develop a common understanding of the term "infant mental health"; (2) focus on the role that Early Head Start and Migrant Head Start programs—in collaboration with their community child care and early education partners—play in promoting the social and emotional development of infants and their families; and (3) identify action steps as part of a comprehensive initiative to address infant mental health using Head Start as a leader for the field. (For more details on the meeting and on suggested action steps, see the full report from which this article is excerpted, *A Commitment to Supporting the Mental Health of Our Youngest Children: Report of the Infant Mental Health Forum*, to be available on the Head Start Web page in the future.)

Defining Infant Mental Health

Charles Zeanah, M.D., a keynote speaker at the Infant Mental Health Forum, defined infant mental health as emotional and social competence in young children who are developing appropriately according to biology, social relationships, and culture. This definition emphasizes the multiple contexts in which infants operate as well as the change inherent in infant development. Normal paths of development within various domains serve as reference points to assess infant competence. Factors that increase the risk of suffering, developmental deviance, or maladaptation create threats to mental health. Discussion at the meeting focused on the context for mental health, including age-appropriate developmental sequence; parental factors; relationships between young children and parents; and factors in the broader family context and environment that affect child development.

Zeanah also addressed the reluctance that many people feel toward using the term "infant mental health" because "infant" is associated with innocence and beginnings, but "mental health" with maladjustment and major mental illness. He argued that the term brings attention to the real suffering and needs of infants and brings to the table a wider array of disciplines and experts to address collectively the problems that families are facing.

Role of Early Head Start and the Child Care Community

The mental health provisions included in the Head Start Program Performance

Standards guided discussion to address promotion, preventive intervention, and treatment. Promoting the mental health of infants is central to everything high quality early care and education programs do. These programs continuously build and nurture relationships which support the social and emotional development of infants and their primary caregivers. Teachers interact with infants during feeding and diapering, for example, as well as engage parents in the care of their child. Early experiences with caring adults play an important role in preparing children to explore and learn and set the stage for all future development.

Factors such as maternal depression, domestic violence, poverty, homelessness, and a lack of supports for the family pose challenges to mental health promotion among some Head Start families. These challenges are even more difficult when a child has biological problems such as prematurity, low birth weight, a disability, or a regulatory disorder. The strong relationships programs develop with families enable them to have a unique vantage point to observe problems or the emergence of problems, and to have the trust and respect of families in order to provide or coordinate the help they may need. Thus, program staff need to understand the factors that influence infant mental health and how their work with families can best support mental health and emotional development. Programs will also need to have relationships with other providers in the community who are able to offer more intensive and specialized services.

Early care and education alone cannot provide the range of services needed to support emotional development of infants and their families. Similarly, a small dose of mental health services cannot be the all-healing remedy for those infants and their families who are most challenged. A continuum of services and supports are needed to meet the individual needs of infants and their families over an extended period of time. These services should be provided by those in the community most qualified to offer the particular services and support.

At the Forum, four Early Head Start programs with promising mental health practices presented their models. Three of the programs have social work professionals on staff to serve families, and the fourth uses external consultation in collaboration with a local mental health clinic. Themes that emerged from their presentations were the need to support frontline staff with reflective supervision (*see article, Reflective Supervision, on page 34*) and the need to establish working relationships with a variety of community network agencies.

Participants at the Forum recognized the challenges of moving forward to address the emotional health of infants and their families, but believe the research and experiences in the field necessitate the development of a more purposeful approach to infant mental health.

Action Steps for Consideration

Forum participants worked in discussion sessions to identify action steps necessary to fully address infant mental health. Their suggestions (the specifics of which are included in the full report) fall within two broad categories: action steps that are specific to Head Start, and action steps that relate to the broader early care and education field. While many participants commented that some of the Head Start specific steps should begin immediately—especially given the role of Head Start as a national laboratory—they recognized that infant mental health transcends Head Start. Efforts should be undertaken to build the capacity throughout the child care and early education field and related health, mental health, and social service professions to increase understanding of early emotional health and appropriate responses. Only then will the nation be able to support the emotional health of all infants and their families. Suggested action steps address the areas of program guidance, public awareness, public policy, professional development, reflective supervision, cross-disciplinary collaboration, financing, research and evaluation, demonstration, and a national agenda on infant mental health. (*For more information on action steps, see page 48 of the article, Guiding Principles.*)

First Steps

Already, the Administration on Children,

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GUIDING PRINCIPLES

BY DEBORAH RODERICK STARK,
RACHEL CHAZAN-COHEN, AND JUDITH HERALD

Photography by Eyewire

PARTICIPANTS AT THE INFANT MENTAL HEALTH FORUM, held in October 2000 (*see article on page 46*), recognized that a comprehensive approach to the emotional health of infants and their families must be guided by a set of principles that influence policy, programming, service delivery, materials development and dissemination, training, technical assistance, research, and funding. Like the priniciples that undergird the Early Head Start program, the principles outlined below convey respect for the individual, appreciation of strengths, and the need for continuous, stable, and accessible relationships and supports. The guiding principles define the ways in which the systems—early care and education, early intervention, health, and higher education—can work individually and collectively to create an environment that honors the relationships necessary for promoting the emotional health of infants and their families.

All pregnant mothers and their partners and new parents need to have relationships that support their emotional well-being and prepare them for the joys and challenges of parenthood. All infants need to have stable, loving relationships with their parents and other primary caregivers for their cues to be understood and addressed in ways that support and nurture their emotional development. For the infant and for the adults who care for them, these relationships need to be—

Individualized: Attention must be given to individual needs. Responsive caregiving that acknowledges and addresses the infant's needs and behavioral temperament will convey the respect and security essential for early emotional development. It is equally important to recognize the individual needs of parents; attending to the parents' issues (e.g., maternal depression, substance use) can enable parents to more comfortably engage in a beneficial relationship with their infant.

Strengths-based: Early relationships must emphasize the strengths and resources of each participant. Everyone has strengths, even the newborn. Helping parents understand their own strengths and the strengths of their infant builds their confidence and supports parent and infant interactions. This is not to obscure the fact that many families have significant needs. Rather, by building on strengths, trusting relationships can be built that will make addressing families' needs more successful.

Continuous and stable: For infants, continuous and stable caregiving builds confidence that their needs will be met. It is important for infants who are cared for out of the home to have a long-term relationship with a primary caregiver. For parents, knowing that there are consistent people they can turn to—the child's caregiver, a home visitor, extended family—is equally important. There is no silver bullet for promoting emotional development or addressing mental health needs, and emotional wellness will not be realized overnight. The more complex the needs of the family and infant are, the more intense and extensive the services should be. Early care and education programs can promote emotional development through best practices that focus on relationships. But, it is unrealistic to expect that these programs can provide the more intensive services infants and families with complex needs must have. A well-coordinated continuum of community-based services and supports are needed to provide the family with the targeted support they need at any particular point in time.

Accessible: Relationships need to be accessible and responsive to when and how the infant and parent need attention and support. Parents must understand the rhythm of the infant, being mindful of the cues the infant sends. Parents and caregivers also need to be participants in supportive relationships. The availability of family and program staff and administration to the parent and caregiver, helps to meet the individual needs of the adults, making them better able to engage in responsive interactions with the infant.

These early relationships, which provide the foundation for future social, emotional, and cognitive development, must be supported by systems that are—

Child focused and family centered: The services, training, policy, funding, and research of systems must support the well-being of the infant and active involvement by family members to achieve optimal infant development. A true family-

centered system includes family members as equal partners with caregivers and administrators in a cohesive, responsive, respectful, and interdependent team focused on meeting the child's and family's needs to support emotional health.

Culturally responsive: Systems need to recognize the importance of understanding the values, beliefs, and practices of diverse cultures. Systems should integrate diversity into the policies, practices, and products of the organization so that the ultimate interactions with individual children and their families can be mindful of and honor their culture.

Community-based: Community-based systems offer targeted services and supports that reflect the particular needs, strengths, resources, and cultures of the community. Staff members from the community further enrich the appropriateness of interactions that support infants and their families.

Comprehensive, coordinated, and integrated: In addition to being based in the community, systems need to offer comprehensive services and supports to infants and their families that reflect the continuum of care needed—from promotion to prevention and treatment. No one agency can fulfill all the needs of families and infants. It is critically important that across the community, systems are coordinated so that the broad range of factors, needs, and contexts are addressed. This ensures that resources and opportunities—including training opportunities—are shared.

Committed to continuous improvement and reflective supervision: At every level, systems must be committed to creating an environment that values and practices continuous improvement. Reflective supervision is a very important piece of this safe, nurturing environment. Staff can regularly reflect on their experiences and gain new knowledge and perspectives that will help them better approach their work with infants and families. Fortunately, the early care and education field is increasingly recognizing the value of reflective supervision both for the emotional support it brings to the staff and for the enhancement of services and supports to the family. Many are hopeful that with appropriate information and training, more programs will include this component in their program. Research that helps programs measure the effectiveness of their interventions is another important piece of continuous improvement. Knowing what works for whom and how and why can be a critical guide for ensuring that resources are expended in ways that are most effective and efficient.

Across Head Start and the broader early child care and education field, several themes emerge in the action steps outlined by the Forum participants. These include—

Program guidance: Inform early care and education programs and related providers in the community about the principles of infant mental health and the appropriate roles they can play in supporting emotional wellness.

Public awareness: Increase public awareness about infant mental health to reduce the stigma associated with it and help the general public understand the importance of relationships in overall infant development and well-being.

Public policy: Promote public policy that acknowledges the importance of early social and emotional development and provides direction and adequate funding to build collaborative systems in communities to support infants and families.

Professional development: Develop evidence-based curriculum and training resources and opportunities that are culturally appropriate and enhance the knowledge and skills of all those working with infants and families.

Reflective supervision: Build the capacity for reflective supervision in early care and education settings to enhance the quality of interactions caregivers are able to offer.

Cross-disciplinary collaboration: Stimulate and formalize cross-disciplinary collaboration—sharing resources, joint training, coordinated planning and service delivery—that will build systems of care in communities to provide the continuum of supports and services needed to focus on emotional health promotion, prevention, and treatment.

Financing: Identify and secure financing to cover the continuum of mental health services needed by infants and their families.

Research and evaluation: Support ongoing evaluation to ensure that practice is informed by research and to measure the

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BY RHONDA C. BOYD AND MICHAEL LOPEZ

THE HEAD START MENTAL HEALTH RESEARCH CONSORTIUM

IN 1997, FIVE RESEARCH GRANTS WERE FUNDED through a collaboration between the Administration on Children, Youth and Families and the National Institute of Mental Health, as the core component of a research initiative designed to develop and study new approaches for preventing, identifying, and treating the mental health concerns of young children served by Head Start. These researchers, Federal staff and Head Start partners, as well as other researchers conducting similar research, comprise the Head Start Mental Health Research Consortium (HSMHRC). The goals of the HSMHRC are to—

- identify the current range of mental health related services;
- determine the types, rates, and severity of mental health problems; and
- assess the impact of home-based and classroom-based skills training interventions on children's mental health problems or overall social and emotional functioning.

The five projects are—

1. *Cross-Cultural Analysis of the Early Screening Project.* Institute On Violence and Destructive Behavior, College of Education, University of Oregon. (Principal Investigator: Hill Walker)
2. *UNC-Head Start Partnership on Mental Health Interventions.* Frank Porter Graham Child Development Center, The University of North Carolina at Chapel Hill. (Principal Investigator: Donna Bryant)
3. *Systematic Early Detection and Self-Determination Approach for Mental Health Intervention in Head Start.* Special Education/At-Risk Program, College of Education, University of New Mexico with partners at the University of California, Los Angeles. (Principal Investigator: Loretta Serna)
4. *Early Identification and Prevention of Conduct Disorder in Head Start Children.* Peabody College, Vanderbilt University with partners at Pennsylvania State University (Principal Investigator: Ann Kaiser).
5. *The Emotional Health of Low-Income Children Over Time: Influences of Neighborhood, Family, Head Start, and Early School Experiences.* Teachers College, Columbia University with partners at Harvard University. (Principal Investigator: Jeanne Brooks-Gunn)

Photography by Indiantown MHS

A classroom- and culturally-based program focusing on skill building improved interaction

These projects are in the fourth year of their 5-year research grants. A few preliminary findings are presented below. (The variability in percentages reported for each of these areas is the result of different settings, samples of children, and assessment measures across the different sites that comprise the HSMHRC.)

Rates of problems

- Approximately 10% to 34% of children are described by their parents and teachers as experiencing problems with anxiety, depression, fears, sleep, and withdrawal.
- Approximately 8% to 52% of children are described by their parents and teachers as exhibiting aggressive and destructive behavior.
- Approximately 10% of Head Start children are reported by their teachers as being aggressive every day. This percentage is similar to what is seen for preschoolers in other child care settings.
- Almost 50% of parents report that their children have less than average social skills.
- Head Start children exhibiting problems with anxiety, depression, fears, and withdrawal symptoms are also more likely to be reported as having low social skills.
- As Head Start children become older, they are more likely to be able to control their impulses, but the ability to control their impulses is harder when the children are in groups with peers.
- A classroom-based, culturally adapted prevention program focusing on

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TOP PICKS

The following resources are highly recommended

[1] FROM NEURONS TO NEIGHBORHOODS: THE SCIENCE OF EARLY CHILDHOOD DEVELOPMENT

Jack P. Shonkoff & Deborah A. Phillips, Editors (2000)

From Neurons to Neighborhoods is a report of the work of the Committee on Integrating the Science of Early Childhood Development of the National Research Council and the Institute of Medicine. It is a comprehensive and up-to-date reference work available for the early childhood field. The findings, conclusions, and recommendations are supported by almost 80 pages of references. *This publication can be printed off the Internet or order at www.nap.edu/catalog/9824.html ($39.95).*

[2] HANDBOOK OF INFANT MENTAL HEALTH, SECOND EDITION

by Charles H. Zeanah Jr., Editor

This volume offers a sweeping analysis of the developmental, clinical, and social aspects of mental health from birth to age three. This second edition reflects changes in the field in the past decade, and contains new chapters on the psychology of pregnancy, neurobiology of fetal and infant development, and examination of mental status in infancy. *Order at www.therapeuticresources.com/cgi-bin/shopper.cgi?267-23text.html ($75.95).*

[3] REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA

This Report represents collaboration among three major Federal Departments: the Department of Health and Human Services, the Department of Education, and the Department of Justice. It introduces a blueprint for addressing children's mental health needs in the United States. *To access the report, visit <phs.os.dhhs.gov/CMH/childreport.htm>*

ARTICLES/REPORTS

DEC (DIVISION OF EARLY CHILDHOOD) RECOMMENDED PRACTICES IN EARLY INTERVENTION/EARLY CHILDHOOD SPECIAL EDUCATION

Sandall, McLean, Smith (Eds.) (2000)

Order at www.sopriswest.com or call (800) 547-6747 ($20.00).

LESSONS FROM THE FIELD: HEAD START MENTAL HEALTH STRATEGIES TO MEET CHANGING NEEDS (EXECUTIVE SUMMARY)

Order at <ccpmcnet.Columbia.edu/dept/ncop/lessons.html>

VIDEOS/TOOLKITS

MENTAL HEALTH IN HEAD START: IT'S EVERYBODY'S BUSINESS

(English and Spanish) Order by fax at (703) 683-5769, or by E-mail at www.headstartinfo.org/cgi- (www.hskids.tmsc.org/cgi-bin/Introduction.cfm#Order).

MENTAL HEALTH TOOL KIT: MENTAL HEALTH RESOURCES FOR TRAINING AND TECHNICAL ASSISTANCE

Order at <www.headstartinfo.org/infocenter/mentalhealth/mh_tkbok.htm>.

THE POWER OF QUESTIONS: BUILDING QUALITY RELATIONSHIPS WITH INFANTS AND FAMILIES

Rebecca Parlakian (2001)

Order at www.zerotothree.org/bkstr_support.html ($7.50).

1. RESEARCH ON THE RISK FACTORS FOR EARLY SCHOOL PROBLEMS AND
2. SELECTED FEDERAL POLICIES AFFECTING CHILDREN'S SOCIAL AND EMOTIONAL DEVELOPMENT AND THEIR READINESS FOR SCHOOL

National Institute of Mental Health (301) 443-4513 or order at <www.nimh.nih.gov/childhp/goodstart.cfm>

THE YEC MONOGRAPH SERIES: PRACTICAL IDEAS FOR ADDRESSING CHALLENGING BEHAVIORS

Order at www.sopriswest.com or (800) 547-6747 ($12.00).

WEBLIOGRAPHY

The following Web sites about mental health are recommended as further resources for teachers, parents, and administrators

1. **www.childrensdefense.org**
THE CHILDREN'S DEFENSE FUND. Includes pages on mental health.

2. **www.nimh.nih.gov**
THE NATIONAL INSTITUTE OF MENTAL HEALTH. Links (www.mentalhealth.org) to the Substance Abuse and Mental Health Services Administration's Knowledge Exchange Network, which provides information about mental health.

3. **www.aboutourkids.com**
THE NEW YORK UNIVERSITY CHILD STUDY CENTER. Useful for parents, teachers, and professionals.

4. **www.actagainstviolence.com**
ADULTS AND CHILDREN TOGETHER AGAINST VIOLENCE. Focuses on adults who raise, care for, and teach children from birth to eight years old.

5. **www.bazelon.org/**
THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW. Links to news and legal analyses with a focus on children's issues.

6. **www.mentalhealth.org/cmhs**
THE CENTER FOR MENTAL HEALTH SERVICES. Created to assist adults and children with serious emotional disorders.

7. **www.ffcmh.org**
THE FEDERATION OF FAMILIES FOR CHILDREN'S MENTAL HEALTH. Offers information on government policy and research as well as links to informational resources for parents. Hosts a Spanish language version.

8. **www.calib.com/nccanch**
THE NATIONAL CLEARINGHOUSE ON CHILD ABUSE AND NEGLECT INFORMATION.

THE UNIVERSITY OF ILLINOIS IS PARTNERING with the University of Colorado at Denver, the University of Connecticut, the University of South Florida, Education Development Corporation, Tennessee Voices for Children, and several national professional organizations to create a Center for the Social and Emotional Foundations of Early Learning. The goals and activities of this consortium are designed to strengthen the capacity of Child Care and Head Start to improve the social and emotional outcomes of young children. As evidenced through a variety of recent publications, there is a direct link between social and emotional development and children's successful transition to school. While there are data on practices that are effective in facilitating the social and emotional development of children, this information has not been consistently translated into information that is useful to consumers. The lack of user-friendly information, combined with the growing number of children with challenging behaviors and mental health needs in Child Care and Head Start programs, highlights the need for systematic training efforts related to social and emotional development. The consortium is committed to addressing these issues through: a) a focus on promoting the social and emotional development of children as a means of preventing challenging behaviors, b) a comprehensive, culturally sensitive approach that is inclusive of and responsive to the needs of programs, families, other professionals, and communities, c) the dissemination of evidence-based practices, d) the ongoing identification of training needs and preferred delivery formats of local programs and T/TA providers, and e) collaboration with existing T/TA providers for the purpose of ensuring the implementation and sustainability of practices at the local level. The Center is jointly funded by the Head Start and Child Care Bureaus. For more information, contact Dr. Mary Louise Hemmeter, Project Director, T: 217/333-2760, E: mlhemmi@uiuc.edu. The Center's Website is <www.ed.uiuc.edu/sped/grants/centerec.html>

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Youth and Families is moving forward on suggestions from the Forum. To build on its lessons, the Early Head Start National Resource Center (EHS NRC) will engage in a number of follow-up activities critical to maintaining a sustained focus on this important issue. Activities will include consensus building, training, and dissemination. Within CORE, efforts are underway to encourage relevant research. For example, infant mental health was added as a priority for the Head Start University Partners Grants. Additionally, the Child Care Bureau convened a National Leadership Forum with child care, health, and mental health professionals on March 6, 2001. Importantly, all three units—the Head Start Bureau, the Child Care Bureau, and CORE—have agreed to work together on implementation of all aspects of follow-up to the Infant Mental Health Forum, recognizing that together their efforts will be more effective and reach across the early child care and education field.

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long-term community impacts of increased focus on infant mental health.

Demonstration: Conduct demonstration efforts to help the early care and education community gather new knowledge and test models and assumptions, ultimately providing more targeted and effective services to infants and their families.

A national agenda on infant mental health: Build a universal commitment to address infant mental health to transcend the scope and responsibility of Head Start. To offer the continuum of services that will support emotional development, it is imperative that the broader caregiving community and related providers (e.g., social work, psychology, psychiatry, nursing, pediatrics, obstetrics, family health) come together. *For more information on this national agenda, contact Lynette Kimes of the EHS National Resource Center at l.kimes@zerotothree.org.*

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skill building for all children in selected Head Start classrooms showed some benefit for attentional skills, social interaction, and adaptive behavior of children.

Future Directions

An important element of this collaborative mental health research consortium is that for several crucial child, parent, and classroom characteristics or domains, similar information was collected across two or more projects. This approach will allow important cross-site comparisons. The HSMHRC is in the process of gathering the cross-site information to report major findings on the mental health of more than 2,400 Head Start children across different geographic regions, populations, and program approaches.

The major aims of the cross-site effort are to investigate risk and protective factors related to mental health problems; exposure to violence; classroom quality and teacher characteristics; parental depression; mental health needs of Head Start children; and accurately screening mental health problems.

These cross-site aims are consistent with the initial goals of the HSMHRC, but also address some of the pertinent issues facing a broader range of Head Start children, families, and staff across the country.

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Dear Reader:

Even before the tragic events of September 11, 2001 the Head Start Bureau had set its sights on strengthening our Infant and Child Mental Health training, research, technical assistance, policy and practice. This is reflected in this issue of the *Head Start Bulletin* that we are proud to present to you. In addition, we are pleased to announce two mental health initiatives that we feel will contribute greatly to meeting the mental health needs of and challenges faced by our Head Start children, families, and staff.

In order to build on the momentum and knowledge generated from the October 2000 Head Start Forum on Infant Mental Health (*see page 46*), the Early Head Start National Resource Center (EHS NRC) has been commissioned to engage in crucial follow-up knowledge development/dissemination, policy development, and practice development activities. The Center on the Social and Emotional Foundations of Early Learning is a new project jointly funded by the Head Start and Child Care Bureaus (*see page 52*). Among the tasks of the new national Center will be the identification of evidence-based practices for promoting social and emotional development and preventing challenging behaviors, the development of training and technical assistance material on evidenced-based practices, and the support of evidenced-based practices at the local level. The Center and the EHS NRC will work closely together.

We are very excited about the work that has occurred to date with respect to mental health in Head Start. We are equally excited about the anticipated contributions of our new initiatives. We hope you will find this issue of the *Bulletin* a useful resource for meeting the mental health needs of the children in your life.

George L. Askew, M.D., F.A.A.P.
Chief, Health and Disabilities Branch, Head Start Bureau
Medical Advisor to the Commissioner of ACYF

Daily Separations and Reunions ■ Stress and the Developing Brain ■ The Effects of Violence ■ [illegible]

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